REPORT 3

PATTON STATE HOSPITAL

November 26-30, 2007

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

The Court Monitor is responsible only for monitoring and providing an independent evaluation of Patton State Hospital's compliance with the Enhancement Plan.

The Court Monitor is not in any way responsible for the services provided at Patton State Hospital or for outcomes of these services for any individual resident at the facility during or following the tenure of the Enhancement Plan. Neither the Court Monitor nor his experts are in any way responsible for the administration of the facility, the day-to-day clinical management of the individuals served, clinical outcomes for any individual, staffing, outcomes for staff providing services at the facility or any other aspect of the operations of Patton State Hospital. All decisions regarding the facility, its clinical and administrative operations and the individuals it serves are made independently from the Court Monitor.

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Introduction

A. Background Information

The evaluation team, consisting of Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Victoria Lund, Ph.D., M.S.N, A.R.N.P.; Ramasamy Manikam, Ph.D.; Elizabeth Chura, M.S.R.N.; and Monica Sage, OTR/L) visited Patton State Hospital (PSH) from November 26 to 30, 2007 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

The progress assessment is outlined in this compliance report, which follows the exact sequence of steps as written in the EP. The report covers Sections C through J (Sections A and B contain definitions and principles that do not entail action steps requiring assessment). For each section, a brief narrative summarizes the findings of the entire section in terms of accomplishments and deficiencies. This is followed by details of compliance assessment. The assessment is presented in terms of:

1. The methodology of evaluation, summarized in one cell at the beginning of each section or major subsection (C1, C2, D1 through D.7, E, F1 through F 10, G, H., I and J);
2. Current findings focused on the requirements in each action step of the EP; this includes, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

To reiterate, the Court Monitor's task is to assess and report on State facilities' progress to date regarding compliance with provisions of the Enhancement Plan (EP) that was negotiated between the State and the United States Department of Justice. In fulfilling that responsibility, the Court Monitor makes recommendations for changes and enhancements to current practices that he and his team believe can help the facilities achieve compliance in the future. The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in every action step in the EP.

The Court Monitor's recommendations are guided by current generally accepted professional standards of care, current literature and relevant clinical experience. These recommendations are linked to the current stage of the facilities' implementation of the EP. At early stages, many of the recommendations are more focused on process deficiencies. As the facilities make progress in their areas, the recommendations will be directed to clinical outcomes to individuals as required by specific provisions of the EP.

The EP mandates the findings of compliance, but it does not mandate the means by which the facilities' caregivers and administrators execute their responsibilities to individuals or the processes and tactics by which the facilities achieve compliance with the terms of the EP. As noted earlier in this report and in every previous report, a facility is in fact free to use any mechanisms it wishes to implement and achieve compliance with the terms of the EP. The California DMH, however, may impose certain statewide policies, practices and procedures to effect improvements in its hospitals.

B. Methodology

The evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included, but were not limited to, charts of individuals, facility administrative directives, policies and procedures, the State's special orders, and facility's internal monitoring and key indicator data. The charts of individuals were selected both randomly and on the basis of adverse outcomes in specific areas. While on site, the evaluators also interviewed administrative, clinical staff and some individuals and observed a variety of therapeutic, rehabilitative and other service delivery processes. The data provided by the facility were verified on a random basis to assess accuracy and reliability.

C. Statistical Reporting

The following statistical abbreviations used in the report are defined as follows, unless otherwise noted in the body of the report:

Abbreviation	Definition
N	Total target population
n	Sample of target population reviewed/monitored
%S	Sample size; sample of target population reviewed/monitored (n) divided by total target population (N) and multiplied by 100
%C	Compliance rate (unless otherwise noted)

In general, PSH appears to have made progress in adhering to the above definitions and in achieving more appropriate sampling methodology compared to the previous review. As needed, this monitor re-characterized the facility's data in this report, usually by naming the process or group that was audited/monitored and providing a summary of the relevant monitoring indicators and corresponding compliance rates.

D. Findings

This section addresses the following specific areas and processes that are not covered in the body of the compliance report.

1. Key Indicator Data

The key indicator data provided by the facility are graphed and presented in the Appendix. The following observations are made:

a. The key indicator data are an essential ingredient of a culture of performance improvement. While they are provided to the Court Monitor as required by the EP, the primary users of the data should be the clinical and administrative leadership and management of the facility.
b. PSH's population has been relatively stable over the reporting period.
c. PSH's key indicator data suggests some positive trends, including:
    i. There appears to be a slight moderation in weight gain and increases in body mass index (BMI) in some BMI categories.
    ii. There appears to be a decline in the use of combined pharmacotherapy.
    iii. There has been a strong decline in the number of falls resulting in major injury and in the recurrence of falls.
    iv. Non-adherence to WRP is on the decline and month-to-month volatility in this indicator has declined.
    v. The use of older anticonvulsants has declined over the past 12 months.
    vi. The number of episodes of hyperglycemia in individuals diagnosed with diabetes appears to be under control.
d. The key indicator data triggers concern in several areas, such as:
    i. The number of individuals alleging abuse, neglect, and/or exploitation has risen over the past six months. This reading may be a result of more effective data collection but should be confirmed.
    ii. There has been in a spike in the number of cases of MRSA. ASH reported that a similar "spike" was due in fact to changes in the way the facility counted MRSA status; PSH should confirm if this is the cause of its own spike.
    iii. There was a significant spike in PRN usage in August and September 2007.
    iv. Similarly, there was a large spike in Stat medication usage in July and August 2007. The timing of these two spikes raises particular questions of relationship and causality.
e. The data reveals patterns that should be noted, investigated and explained by the facility:
    i. There is apparent cyclicality in a number of indicators, such as two or more aggressive acts to others in seven days, more than three episodes of restraint in seven days, and suicidal threat/ideations. The cyclicality is sufficiently pronounced to appear to not be random. What is causing these swings?
    ii. Homicidal threats/ideations are on the rise after declining for a period of time. This bears examination to determine the reason.

iii. The total number of medication variances reported fell from a high of 102 in November 2006 to a low of 19 in August 2007. It is still unclear how accurately the facility is capturing variances. If in fact the August 2007 count is correct, there is an opportunity to analyze what happened in that month to produce so few variances and to incorporate that learning into the facility's practices.
iv. The number of external hospitalizations is rising—why? Change in patient population, changes in medical attention to individuals, other reason(s)?

f. .It is the monitor's recommendation that the DMH undertake an analysis of each facility's key indicator data on a quarterly basis. The resulting analysis should be reviewed by the State with its Chief CRIPA Consultant. The outcome of this review should be that the hospitals: (a) use the same statewide definitions for all key indicators; (b) standardize their data collection and data analysis methodologies, (b) improve their services, and (c) use the data for future policy decisions. The DMH Chief CRIPA Consultant should update the monitor on these efforts following each review. It is critical that the key indicator data are valid and reliable, and used to enhance the mental health services provided throughout the DMH system.

2. Monitoring, mentoring and self-evaluation

In general, PSH has made progress in self-monitoring, data gathering, aggregation and analysis since the previous assessment. The following observations are relevant to this area.

a. Despite persistent and serious staffing shortages in some core clinical disciplines, PSH has maintained structures required for the processes of self-monitoring and assessment.
b. As in the previous reports, the facility's self-monitoring data generally had integrity, were reasonably well organized and the data presented were relevant to requirements of the EP. The leadership provided by the Director of Standards Compliance continues to be essential to this task.
c. The facility's self-monitoring data regarding the process and content of Wellness and Recovery Planning (Sections C1 and C2) were based on the DMH standardized tools. As mentioned in previous reports, these tools contain indicators and operational instructions that are consistent with EP requirements.
d. The California DMH, with the assistance of PSH's Chief of the Forensic review Panel (FRP), has developed a Manual for the Preparation of PC 1026 and PC 1370 Court Reports. This Manual provides clear guidance to the Wellness and Recovery Planning Teams (WRPTs) regarding the process and content of court assessments and includes standardized monitoring tools (with indicators and operational instructions that are appropriate to EP requirements).
e. The DMH has yet to finalize current efforts to streamline and standardize the tools used for disciplinary assessments and services. The current tools that are used to assess psychiatric assessments and reassessments, inter-unit transfer assessments, nutrition assessments, high-risk medication uses (PRN medications, benzodiazepines, and anticholinergics) and

some aspects of medical service delivery are generally well aligned with requirements of the EP. However, not all the tools address the quality of services or include operational definitions and instructions that can standardize the use within and across the facilities.

f. PSH has improved the sampling methodology during this review period, including a review of up to a 100% sample in some areas (e.g. court assessments). However, more work is needed to ensure at least a 20% sample of appropriately defined target populations.
g. PSH reported mean compliance rates of 0% with many provisions of the EP. In many cases, the rates are calculated by evaluating compliance with multiple nested requirements. The facilities should conduct data analysis to assess specific areas of low compliance and identify and resolve obstacles to compliance.
h. PSH has yet to ensure that self-monitoring has a strong mentoring component and that the facility has sufficient complement of senior clinicians who can serve as mentors to the WRPTs.
i. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each hospital. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with their Chief CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.
j. The DMH has yet to ensure that the tools and data collection are automated.

3. Implementation of the EP

a) Structure of current and planned implementation:
   i. PSH has made further progress in the systems of review and analysis of court assessments for individuals admitted under PC 1026 and PC 1370.
   ii. PSH has made some progress in the following areas
      1) Attitude of WRPTs towards the individuals during team meetings;
      2) Implementation of the initial WRPs within 24 hours of admission;
      3) Recent restructuring of the WRP training team;
      4) Scheduling of individuals for active treatment hours;
      5) Number of medication education groups on the Mall;
      6) Timeliness of the psychological assessments;
      7) Structure of the PBS team;
      8) Quality of nutritional assessments and services, despite staffing shortages;
      9) Reporting of adverse drug reactions (ADRs) and medication variances; and

10) Monitoring of elements of medical care related to diagnostic testing.

iii. PSH must strengthen clinical supervision and accountability especially in areas where the facility appears to have made no progress or lost momentum since the last review (e.g. training of the WRPTs on the process and content of WRP, substance abuse programming and the process and content of admission psychiatric assessments).

iv. The medical staff and its leadership are essential to successful implementation of the EP. Each DMH hospital should develop and implement a formalized system for the Psychiatry Department to provide staff with proper oversight, clinical and administrative support and development as well as implementation and coordination of monitoring, educational and peer review systems. Each facility should create a dedicated permanent position for Chief of Psychiatry. This position should have both authority and responsibility regarding the clinical assignments of staff psychiatrists, the assignment of senior psychiatrists to various mentoring and monitoring functions, supervision of all psychiatrists and compliance with the EP in the areas of WRPT leadership and psychiatric assessments and services.

v. The DMH needs to finalize efforts to reorganize and automate the processes of assessments and WRPs, and then initiate a major overhaul of the current charting system at PSH. As mentioned in previous reports, the current charting system must be revamped to facilitate access by clinicians to needed data, particularly during an emergency.

vi. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH seriously consider standardizing across all hospitals the Administrative Directives that impact these services.

b) Function of current and planned implementation:

i. PSH has achieved substantial compliance with requirements of the EP in the area of court assessments of individuals who were admitted under PC 1026 and PC 1370 (Section D.7). In order to maintain this level of compliance, the facility must continue feedback by the Forensic Review Panel (FRP) to the WRPTs on an ongoing basis as well as full implementation of the principles and practice guidelines in the DMH Manual regarding this area.

ii. PSH has yet to improve compliance with EP requirements regarding Wellness and Recovery Planning. Discipline seniors should be trained to not only monitor, but also to mentor clinicians in their areas. The team meetings attended by the monitor showed that the facility has not made sufficient progress in integrating the principles and practice guidance in its WRP Manual into the day-to-day operations of the WRPTs.

iii. Functional outcomes of the current structural changes have yet to be identified and implemented to guide further implementation.

iv. PSH has yet to make progress in achieving appropriate linkage between interventions provided at the PSR Mall and objectives outlined in the WRP.

v. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:

1) **Mall hours**: The number of hours of Psychosocial Rehabilitation Mall (PSR) services (i.e., group facilitation or individual therapy) provided by the various disciplines, administrative staff, and others is currently minimal. The following table provides the minimum average number of hours of Mall services that DMH facilities should provide:

DMH PSR Mall Hour Requirements

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Before 8am: Supplemental activities	Before 8am: Supplemental activities	Before 8am: Supplemental activities	Before 8am: Supplemental activities	Before 8am: Supplemental activities	Supplemental activities	Supplemental activities
8am – 6pm: Active treatment Official Mall Hours: Groups A: Morning group B: Morning group LUNCH C: Afternoon group D: Afternoon group Individual therapy Non-ABCD hours	8am – 6pm: Active treatment Official Mall Hours: Groups A: Morning group B: Morning group LUNCH C: Afternoon group D: Afternoon group Individual therapy Non-ABCD hours	8am – 6pm: Active treatment Official Mall Hours: Groups A: Morning group B: Morning group LUNCH C: Afternoon group D: Afternoon group Individual therapy Non-ABCD hours	8am – 6pm: Active treatment Official Mall Hours: Groups A: Morning group B: Morning group LUNCH C: Afternoon group D: Afternoon group Individual therapy Non-ABCD hours	8am – 6pm: Active treatment Official Mall Hours: Groups A: Morning group B: Morning group LUNCH C: Afternoon group D: Afternoon group Individual therapy Non-ABCD hours		
After 6pm: Supplemental activities	After 6pm: Supplemental activities	After 6pm: Supplemental activities	After 6pm: Supplemental activities	After 6pm: Supplemental activities		

Required PSR MALL Hours as Facilitators or Co-Facilitators		
	Admissions Staff	Long-Term Staff
Psychiatry	4	8
Psychology	5	10
SW	5	10
RT	7	15
RN	6	12
PT	6	12
FTE Mall staff	20 hours as Mall group facilitator	
Other hospital staff	As determined locally at each hospital	

The Long-Term staff Mall hours are also specified in the DMH Long Term Care Services Division Strategic Plan FY 2007-2009. The hours have been reduced for the Admissions clinical staff because of the heavy assessment workload and increased number of Wellness and Recovery Planning Conferences (WRPCs) that are held during the first 60 days of admission. There is no reduction in the required 20 hours of Mall services provided to the individuals.

It is expected that during fixed Mall hours, the Program/Units will be closed and all unit and clinical staff will provide services at the PSR Mall. Each hospital should develop and implement an Administrative Directive (AD) regarding the provision of emergency or temporary medical care during Mall hours.

2) **Progress notes**: PSH has yet to implement a requirement for providers of Mall groups and individual therapy to complete and make available to each individual's WRPT the DMH-approved PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no basis for revising an individual's objectives and interventions. This is not aligned with the requirements as stated in the DMH WRP Manual. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies.
3) **Cognitive screening for PSR Mall groups**: PSR Mall groups should be presented in terms of the cognitive levels of the individuals at the hospital. Individuals can be stratified at three cognitive levels: (a) advanced (above average), (b) average, and (c) challenged (below average). A cognitive screening protocol, utilizing generally accepted testing methods, can be used to determine these levels for those individuals whose primary or preferred language is English.

The cognitive screening protocol will also provide information for the team psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that no later than January 1, 2008, cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

4) **PSR Mall, Vocational Services and Central Program Services (CPS)**: The DMH facilities have made some progress toward developing a centralized PSR Mall service under the direction of the PSR Mall Director. However, not all services have been incorporated in the PSR Mall system, e.g., vocational services and CPS. All facilities must ensure that no later than January 1, 2008, there is a single unified PSR Mall system that incorporates all psychosocial rehabilitation services that are included in the individuals' WRPs.
5) **Virtual PSR Mall**: Those facilities that have individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community, should provide those individuals with that opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific reference to community PSR Mall groups in the interventions. This service should be available to this group of individuals no later than January 1, 2008.

5. Staffing

The PSH staffing table below shows the staffing pattern at the hospital as of October 31, 2007. These data were provided by the facility. The table shows that there continues to be a major shortage of staff in several key areas: senior psychiatrists (100% vacancy rate), staff psychologists, senior psychologists (100% vacancy rate), pharmacy personnel (pharmacist I and pharmacy technicians), clinical dieticians, social workers rehabilitation therapists and psychiatric technicians. PSH has made progress in recruitment of staff psychiatrists since the last review, but more work is needed to fill all required positions.

Patton State Hospital Vacancy Totals as of 10/31/2007

Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	5.00	4.00	1.00	20.00%
Assistant Director of Dietetics	4.00	4.00	0.00	0.00%
Audiologist I	1.00	1.00	0.00	0.00%
Chief Dentist	1.00	1.00	0.00	0.00%

Patton State Hospital Vacancy Totals as of 10/31/2007				
Identified Clinical Positions	**Budgeted Positions 07/08 FY**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Chief Physician & Surgeon	1.00	1.00	0.00	0.00%
Chief, Central Program Services	0.00	0.00	0.00	0.00%
Chief Psychologist	1.00	1.00	0.00	0.00%
Clinical Dietician/Pre-Reg. Clin. Dietician	13.00	10.00	3.00	23.08%
Clinical Laboratory Technologist	1.00	1.00	0.00	0.00%
Clinical Social Worker	101.20	92.00	9.20	9.09%
Coordinator of Nursing Services	1.00	1.00	0.00	0.00%
Coordinator of Volunteer Services	1.00	1.00	0.00	0.00%
Dental Assistant	4.00	4.00	0.00	0.00%
Dentist	2.00	2.00	0.00	0.00%
Dietetic Technician	4.00	4.00	0.00	0.00%
E.E.G. Technician	0.00	0.00	0.00	0.00%
Food Service Technician I and II	122.00	106.00	16.00	13.11%
Hospital Worker	0.00	0.00	0.00	0.00%
Health Record Technician I	11.00	6.00	5.00	45.45%
Health Record Techn II Sp	3.00	2.00	1.00	33.33%
Health Record Techn II Sup	1.00	0.00	1.00	100.00%
Health Record Techn III	1.00	1.00	0.00	0.00%
Health Services Specialist	25.00	25.00	0.00	0.00%
Institution Artist Facilitator	0.00	0.00	0.00	0.00%
Licensed Vocational Nurse	81.00	77.00	4.00	4.94%
Medical Technical Assistant	0.00	0.00	0.00	0.00%

Patton State Hospital Vacancy Totals as of 10/31/2007				
Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Medical Transcriber	6.00	6.00	0.00	0.00%
Medical Transcriber Sup	0.00	0.00	0.00	0.00%
Sr Medical Transcriber	1.00	1.00	0.00	0.00%
Nurse Instructor	5.00	5.00	0.00	0.00%
Nurse Practitioner	5.00	5.00	0.00	0.00%
Nursing Coordinator	11.00	11.00	0.00	0.00%
Office Technician	31.00	29.60	1.40	4.52%
Pathologist	0.00	0.00	0.00	0.00%
Pharmacist I	13.00	10.85	2.15	16.54%
Pharmacist II	1.00	1.00	0.00	0.00%
Pharmacy Services Manager	1.00	1.00	0.00	0.00%
Pharmacy Technician	11.00	10.00	1.00	9.09%
Physician & Surgeon	20.00	19.65	0.35	1.75%
Podiatrist	1.00	1.00	0.00	0.00%
Pre-licensed Pharmacist	0.00	0.00	0.00	0.00%
Pre-licensed Psychiatric Technician	9.00	9.00	0.00	0.00%
Program Assistant	8.00	8.00	0.00	0.00%
Program Consultant (RT, PSW)	2.00	2.00	0.00	0.00%
Program Director	8.00	8.00	0.00	0.00%
Psychiatric Nursing Education Director	1.00	0.00	1.00	100.00%
Psychiatric Technician *	737.00	644.00	93.00	12.62%
Psychiatric Technician Trainee*	0.00	0.00	0.00	0.00%

Patton State Hospital Vacancy Totals as of 10/31/2007				
Identified Clinical Positions	**Budgeted Positions 07/08 FY**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Psychiatric Technician Assistant*	44.10	39.00	5.10	11.56%
Psychiatric Technician Instructor	1.00	1.00	0.00	0.00%
Psychologist-HF, (Safety)	66.20	61.25	4.95	7.48%
Public Health Nurse II	2.00	2.00	0.00	0.00%
Radiologic Technologist	1.00	1.00	0.00	0.00%
Registered Nurse *	335.80	330.00	5.80	1.73%
Reg. Nurse Pre Registered	0.00	0.00	0.00	0.00%
Rehabilitation Therapist	93.90	61.75	32.15	34.24%
Special Investigator	3.00	3.00	0.00	0.00%
Special Investigator, Senior	2.00	1.00	1.00	50.00%
Speech Pathologist I	1.00	1.00	0.00	0.00%
Sr. Psychiatrist (Spvr)	28.20	0.00	28.20	100.00%
Sr. Psychologist (Spvr and Spec)	28.30	0.00	28.30	100.00%
Sr. Psych Tech(Safety)	85.00	85.00	0.00	0.00%
Sr. Radiologic Technologist (Specialist)	1.00	1.00	0.00	0.00%
Sr. Voc. Rehab. Counselor/Voc. Rehab. Counselor	2.00	2.00	0.00	0.00%
Staff Psychiatrist	78.10	74.30	3.80	4.87%
Supervising Psychiatric Social Worker	0.00	0.00	0.00	0.00%
Supervising Registered Nurse	8.00	7.00	1.00	12.50%
Supervising Rehabilitation Therapist	0.00	0.00	0.00	0.00%
Teacher-Adult Educ./Vocational Instructor	16.70	10.00	6.70	40.12%
Teaching Assistant	0.00	0.00	0.00	0.00%

Patton State Hospital Vacancy Totals as of 10/31/2007				
Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Unit Supervisor	27.00	23.00	4.00	14.81%
Vocational Services Instructor (Landscp Gardn)(S)	1.00	1.00	0.00	0.00%

As in other DMH facilities, the staffing shortage at PSH has been worsened by the recent actions of the Court Receiver at the California Department of Corrections and Rehabilitation (CDCR), especially the pay raise in the specialties of psychiatry, psychology and pharmacy. The DMH and the State have recently acted to increase salaries within five percent of parity with the CDCR in the classifications of psychiatry, psychology, social work, rehabilitation therapy and psychiatric technicians. These actions have the potential of resolving this crisis and reversing the negative impact on its mental health institutions. However, the state has yet to address the disparity in the salaries of pharmacists and to head off exodus of physicians and surgeons that is anticipated to occur given the current gap in salaries between CDCR and the DMH.

In order to meet the Enhancement Plan requirements, the overall numbers of nursing staff must increase and the skill mix be expanded. The facility needs sufficient numbers of direct service nursing staff to provide a minimum of 5.5 nursing care hours per patient day (NCHPPD) on all units. If any individual on the unit is on 1:1 observation, an additional staff member should be added to each shift for the period of time an individual is on 1:1 observation, and this additional staff member would not be counted in the overall NCHPPD.

In order to ensure sufficient Registered Nurses to fulfill the requirements of the Enhancement Plan, the nursing staff skill mix should be 35-40% RNs and 60-65% Psychiatric Technicians and/or LVNs. Additionally, there should be a sufficient number of nursing educators, supervisors, and administrators, who should not be included in the calculation of NCHPPD, to ensure that generally accepted professional standards of psychiatric mental health nursing care are fully met.

Psychiatric Mental Health Advanced Practice Nurses and/or Clinical Nurse Specialists should be actively recruited to develop a program and provide education for psychiatric mental health nursing. Within the first 90 days of employment, any nurse who does not have previous experience in psychiatric mental health nursing should be required to complete a basic psychiatric mental health nursing review course.

Finally, there is a critical shortage of hospital police officers and Special Investigators across DMH facilities. This shortage compromises the timeliness of the practices and procedures required for compliance with Section I of the Enhancement Plan. Salary appears to be the key reason that the facilities have not been able to recruit additional staff and have lost staff to the Corrections Department and local communities, despite DMH's vigorous recruitment and training efforts. This situation is serious and must be reversed to achieve compliance.

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future;
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.

F. Next Steps

1. The Court Monitor's team is scheduled to tour Napa State Hospital January 28-February 1, 2008 for a follow-up evaluation.
2. The Court Monitor's team is scheduled to reevaluate Patton State Hospital June 9-13, 2008.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.	**Summary of Progress:** 1. PSH has aligned its ADs with the DMH WRP Manual. 2. The WRPCs show that, in general, WRPT members are respectful of the individuals and make an effort to elicit their input. 3. PSH has conducted self-assessment of compliance based on appropriate tools and methods and the data appear to have been generated with integrity and are presented in a reasonably thorough manner. 4. PSH has recently taken steps to strengthen its WRP training program. 5. PSH has improved its compliance with the requirement to implement the initial WRPs within 24 hours of admission. 6. PSH has made progress in providing the required active treatment hours per week.
1. Interdisciplinary Teams		
C.1	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	**Methodology:** <u>Interviewed</u>: 1. Gari-Lyn Richardson, Standards Compliance Director 2. Sarla Gnanamuthu, MD, Medical Director 3. Wadsworth Murad, MD, Acting Chief of Psychiatry 4. Jana Larmer, PsyD, Standards Compliance Psychologist 5. Julia Fleming, RT, Standards Compliance, WRP trainer 6. George Christison, MD, Acting Chief of Professional Education <u>Reviewed</u>: 1. AD #1.00 Plan for Professional Services (June 2007) 2. AD #15.42, Wellness and Recovery Planning (November 2007)

		3. PSH outline of WRP Psychiatrist Leadership Peer Mentoring 4. PSH Discharge Planning and Community Integration Training Module 5. Staff Development Report: WRP Level I training 6. Staff Development Report: WRP Engagement Module 7. Staff Development Report: WRP Leadership Conference Training 8. DMH Clinical Chart Auditing Form 9. DMH Clinical Chart Auditing Form Instructions 10. DMH Clinical Chart Auditing summary data (May to October 2007) 11. PSH data regarding competency-based WRP training of WRPT members 12. DMH WRP Observation Monitoring Form 13. DMH WRP Observation Monitoring Form Instructions 14. DMH WRP Observation Monitoring summary data (May to October 2007) 15. PSH WRPC Attendance Monitoring Form 16. PSH WRPC Attendance Monitoring summary data (May to October 2007) <u>Observed</u>: 1. WRPC (Program VI, unit EB-01) for 14-day review of SKG 2. WRPC (Program VI, unit EB-01) for monthly review of SDR 3. WRPC (Program IV, unit 36) for quarterly review of KH 4. WRPC (Program I, unit EB-11) for quarterly review of JL
C.1.a	Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure that all ADs, SOs and manuals that address Wellness and Recovery Planning are aligned with the DMH WRP manual. **Findings:** PSH has implemented this recommendation. AD #1.00 Plan for Professional Services (June 2007) and AD #15.42 Wellness and

	determination and independence.	Recovery Planning (November 2007) have been updated and aligned with the DMH WRP Manual. AD #15.42 has a cover memo indicating that all timeframes for WRPCs have been implemented except the requirement for a 30-day WRPC. **Recommendation 2, June 2007:** Continue and strengthen current training program. In addition, the facility needs to ensure that each program has a dedicated trainer, to build the competency of program trainers and to increase training sessions for all members of the WRPTs. **Findings:** Since the last review, PSH has implemented the following changes to its WRP training program: 1. A full-time Rehabilitation Therapist was hired to conduct WRP Overview Training and WaRMSS Training; 2. A full-time Psychologist was hired to conduct Team Leader Training and Engagement Module Training; 3. Team Leader Training curriculum has been developed and implemented; 4. MSH's Case Formulation Module was updated to enhance alignment with EP requirements; 5. Discharge Planning Module has been developed; and 6. A psychiatrist was appointed as the new acting Chief of Professional Education (the former psychiatrist retired). Wellness and Recovery Planning Training has been designated as a focus of responsibility for this position. At present, the facility provides the following training activities: 1. WRP Overview Training: this training has been ongoing for 12 months and consists of a didactic presentation that provides an

		overview of the entire WRP manual and concludes with the statewide 50-question test. 2. Engagement Training: this training is done in small group sessions using the curriculum developed at MSH. PSH has yet to implement the MSH curricula regarding Case Formulation, Foci/Objectives/Interventions and Mall Integration as well as the PSH Discharge Planning Module. In the next six months, PSH plans to continue WRP Overview Training, Engagement Training, and Team Leader Training until all appropriate staff have been trained. The facility also plans to implement the modules regarding Case Formulation, Foci/Objectives/Interventions, Mall Integration and Discharge Planning. The facility has identified the following main barriers to compliance with EP requirements: 1. Lack of senior psychiatrists and delays in the approval of the senior psychiatrist examination; 2. Challenges in recruitment of new staff psychiatrists without a guarantee of the recently approved salary increase (approximately 30 staff psychiatrist vacancies exist); 3. Lack of consistency in the positions of acting senior psychiatrists due to vacancies on the units that require a rotation of psychiatrists acting in senior positions, 4. Lack of analysis of the compliance data to identify reasons for poor compliance. At the request of this monitor, the facility presented the following plan to resolve these barriers: 1. The Medical Director through the Chief of Psychiatry will assign three acting senior psychiatrists to serve as WRP trainers/mentors

		by the end of December. Currently, PSH has two full-time acting senior psychiatrists and anticipates appointing two additional full-time acting senior psychiatrists by February 1, 2008. 2. The Chief of Professional Education and the senior psychiatrists (when positions are filled) will review the WRP monitoring data, on a monthly basis, to identify and assess the areas requiring further mentoring and training. This information will be reported through the Chief of Psychiatry to the Medical Director for corrective action. 3. The senior psychiatrists assigned to the programs will observe the conferences and provide mentoring to the teams, as well as feedback to the teams and the Department of Psychiatry regarding areas requiring improvement. 4. A WRP process template will be developed by senior psychiatrists to assist the teams in meeting EP requirements. 5. The senior psychiatrists will report on patterns and trends as well as barriers to compliance and provide this information through the Chief of Psychiatry to the Medical Director for corrective action. 6. In performing data analysis, the senior psychiatrists will break out subsections of the Plato data to show improvement areas not currently identified due to the all-or-none scoring method used. **Recommendation 3, June 2007:** Provide documentation of competency-based training of all members of the WRPTs. **Findings:** The following is a summary of the facility's data, including percentages of WRPT members who have successfully completed the training (%C) as of November 10, 2007:

WRP Overview Training				
	MD	PhD, SW, and RT	RN	PT
N	70	157	283	672
n	70	157	283	672
%S	100	100	100	100
%C	76	87	39	35

Engagement Training				
	MD	PhD, SW, and RT	RN	PT
N	70	157	283	672
n	70	157	283	672
%S	100	100	100	100
%C	0	3	1	1

The above data show that few WRPT members have completed the engagement training module.

In addition, PSH has data showing that 57 (out of 70) Psychiatrists have received training on Team Leadership on October 21, 2007, but only nine completed the ongoing training as of November 10, 2007.

Recommendation 4, June 2007:
Identify barriers to nursing staff's participation in WRP training and develop and implement corrective actions.

Findings:
PSH reports that the main barrier is the lack of staff to provide training at various times that are appropriate to the schedules of nursing staff. To address this barrier, the facility has provided training sessions at times that are more appropriate to the nurses'

schedule as well as increased these sessions in order to offer staff two different opportunities to meet the training requirement. At present, the training consists of the following:

1. A formal three-hour didactic course; and
2. WaRMSS training combined with the WRP overview training.

Recommendation 5, June 2007:
Provide monitoring data that address this requirement.

Findings:
PSH used the Clinical Chart Form to monitor items relevant to this requirement. The facility reviewed an average sample of 19% of the Quarterly and Annual WRPs due per month (May to October 2007). As mentioned earlier, PSH has yet to implement the required monthly reviews of the WRPs. The following is an outline of the relevant monitoring indicators and corresponding mean compliance rates:

1.	*Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care*	0%
2.	*Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services*	8%

Recommendation 6, June 2007:
Ensure that monitoring data are based on adequate monthly samples of at least 20% of team meetings and charts. This recommendation is relevant to all applicable items in Sections C.1 and C.2.

		Findings: PSH has made progress in sample sizes, but has yet to achieve a 20% sample size monthly on a more consistent basis. Barriers to reaching and maintaining a 20% sample size include coordination of auditing staff and prioritization of auditing. **Other findings:** The monitor attended four WRPCs. The meetings showed minor progress in the overall process of the team meetings. The following are examples of areas of progress: 1. All meetings started on time. 2. The team psychiatrists assumed leadership of all meetings attended. 3. All meetings attended by this monitor included the required core members of the WRPT. 4. The teams made some effort to review the individual's attendance at the assigned groups. 5. The team members were respectful of the individuals and made an effort to elicit their input. However, the meetings showed a general pattern of persistent process deficiencies as follows: 1. The teams did not properly review their assessments of the individual as per WRP process steps. 2. The teams did not review the risk factors as per WRP process steps. 3. The teams did not identify key questions/issues to review with the individual. 4. The updates of the present status were incomplete and did not reflect the current status. 5. The reviews of the discharge criteria were generic or did not occur,

		and the teams did not discuss with the individual progress needed to meet each criterion. 6. There was no mechanism to review progress in Mall groups. 7. The reviews of foci, objectives and interventions were generally not informed by the assessments and the case formulation. 8. The foci did not address all of the individual's needs, including, in one meeting, the main reason for the hospitalization of an individual who was admitted under PC 1370. 9. The teams did not align the objectives and the interventions with the individual's strengths, including the objective of learning ways to non-violence for an individual who was described as a peaceful man, with no history of violence. . 10. The teams did not update the objectives and interventions when no progress was made. 11. In general, the teams had difficulty engaging the individuals in the review of objectives and interventions. In one meeting, the psychiatrist conducted an extended assessment of the individual during the meeting and the team did not address any of the objectives or interventions in the WRP. The above deficiencies indicate that the facility has yet to make significant progress in integrating the principles and practice guidelines in its WRP Manual into the day-to-day operations of the WRPTs. **Compliance:** Partial. **Current recommendations**: 1. Standardize all WRP training modules (Engagement, Case Formulation, Foci/Objectives/Interventions, Discharge Planning/Community Integration and Team Leadership) for use across facilities and ensure that all these modules are aligned with the DMH WRP Manual.

<table>
<tr><td></td><td></td><td>2. Provide outline of all current and planned WRP training activities, including information on who provides the training, brief description of the scope of the training, any changes in the training (type and personnel) since the last review and an update on current barriers to compliance and the facility's corrective actions.
3. Provide documentation of competency-based training of all members of the WRPTs, including all nursing staff.
4. Monitor this requirement based on a 20% sample and provide data analysis (derived from Plato worksheets) regarding areas of non-compliance.
5. Implement all required timeframes for WRP reviews, including the requirement for 30-day reviews in all units.</td></tr>
<tr><td>C.1.b</td><td>Be led by a clinical professional who is involved in the care of the individual.</td><td>Current findings on previous recommendations:

Recommendation 1, June 2007:
Monitor both presence and proper participation by the team leaders in all WRP meetings.

Findings:
PSH used the DMH WRP Observation Monitoring Form to assess its compliance with this requirement of the EP (May to October 2007). The facility reviewed variable samples of the total number of 7-day, 14-day, quarterly and annual WRPCs. The following outlines the mean sample size and compliance rate for each conference. PSH did not provide a breakdown of the data regarding specific areas of low compliance.

<table>
<tr><th>WRPC</th><th>Mean S%</th><th>Mean %C</th></tr>
<tr><td>7-day</td><td>12</td><td>0</td></tr>
<tr><td>14-day</td><td>14</td><td>0</td></tr>
<tr><td>Quarterly</td><td>23</td><td>1</td></tr>
<tr><td>Annual</td><td>13</td><td>4</td></tr>
</table>
</td></tr>
</table>

		To assess the participation of the team leaders, the facility has implemented team leadership training and mentoring and has a plan to use MSH's Psychiatry Team Leadership monitoring form effective January 2008. **Recommendation 2, June 2007:** Address and resolve discrepant auditing findings. **Findings:** There are currently no discrepant findings in the facility's data in this area. PSH reports that all auditors have obtained 90% agreement with the State Consultant in this area. **Recommendation 3, June 2007:** Develop and implement a mechanism to define the total target population and sample sizes in all monitoring. **Findings:** Same as in Findings for Recommendation 6 in C.1.a. **Recommendation 4, June 2007:** Develop and implement a peer mentoring system to assure competency in team leadership skills. **Findings:** PSH reportedly provided a mandatory training of all psychiatrists in the area of team leadership (October 31, 2007) and ongoing training has been provided based on mock conferences. This training is being conducted by the Chief of Professional Education, Standards Monitoring Psychologist, Chief of Psychiatry and Chief of Medical Staff. As mentioned earlier, PSH has a plan to use MSH's Psychiatry Team Leadership monitoring form effective January 2008.

		Other findings: As mentioned in C.1.a, the WRPCs attended by this monitor demonstrate that PSH has yet to make significant progress in this area. **Compliance:** Partial. **Current recommendations**: 1. Monitor both presence and proper participation by the team leaders in all WRP meetings, and provide data analysis regarding the specific areas of low compliance. 2. Implement a peer mentoring system to ensure competency in team leadership skills.
C.1.c	Function in an interdisciplinary fashion.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Same as in C.1.a and C.1.b. **Findings:** Same as in C.1.a and C.1.b. **Recommendation 2, June 2007:** Provide data regarding compliance with each of the four items in this tool. **Findings:** PSH used the previously described Observation Monitoring process to assess compliance (May to October, 2007). The facility reported a mean compliance rate of 0% for each of the 7-day, 14-day, quarterly and annual conferences monitored. PSH did not provide a breakdown of the data regarding specific areas of low compliance.

		Other findings: As mentioned in C.1.a, the WRPCs attended by this monitor demonstrate that PSH has yet to make significant progress in this area. **Compliance:** Partial. **Current recommendations**: 1. Same as in C.1.a and C.1.b. 2. Provide data analysis regarding the specific areas of low compliance.
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Conduct surveys to assess the views of team members regarding the functions of their designated leaders. **Findings:** This recommendation is not needed at this stage. As mentioned earlier, the facility has a plan to use MSH's Psychiatry Team Leadership monitoring form effective January 2008. This tool is sufficient in lieu of this recommendation. **Recommendation 2, June 2007:** Develop and implement a Physician Performance Profile that includes indicators that ensure provision of competent, necessary and appropriate psychiatric and medical care as required in the EP. **Findings:** PSH did not present data regarding implementation of this recommendation.

		Other findings: PSH used the DMH WRP Clinical Chart Auditing Form to assess compliance (May to October 2007). Reviewing a mean sample of 19% of the quarterly and annual WRPCs due per month, the facility reported a mean compliance rate of 0%. PSH did not provide data analysis regarding specific areas of low compliance. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a Physician Performance Profile that includes indicators that ensure provision of competent, necessary and appropriate psychiatric and medical care as required in the EP. 2. The Department of Psychiatry manual should include specific requirements regarding psychiatrists' roles as team leaders that are aligned with the functions of the team leaders as outlined in the WRP Manual. 3. Monitor this requirement using the Clinical Chart Auditing Form and provide data analysis regarding specific areas of low compliance.
C.1.e	Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Same as in C.1.a through C.1.d. **Findings:** Same as in C.1.a through C.1.d. **Recommendation 2, June 2007:** Same as in D.1.a through D.1.e.

		Findings: Same as in D.1.a through D.1.e. **Recommendation 3, June 2007:** Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions. **Findings:** Same as in C.1.a, Recommendation 2 and C.1.b, Recommendation 4. **Other findings:** PSH used the previously described Observation Monitoring process to assess compliance (May to October 2007). The facility reported a mean compliance rate of 0% for each of the 7-day, 14-day, quarterly and annual conferences monitored. PSH did not provide a breakdown of the data regarding specific areas of low compliance. **Compliance:** Partial. **Current recommendations**: 1. Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions. 2. Monitor this requirement and provide data analysis and corrective actions regarding specific areas of low compliance.
C.1.f	Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of	**Current findings on previous recommendation:**

	those results for diagnosis, therapy and rehabilitation by no later than the next review.	**Recommendation, June 2007:** Same as in C.1.a through C.1.e. **Findings:** Same as in C.1.a through C.1.e. **Other findings:** Using the previously described Observation Monitoring process (May to October 2007), PSH reported a mean compliance rate of 0% for each of the 7-day, 14-day, quarterly and annual conferences monitored. PSH did not provide data analysis regarding specific areas of low compliance. **Compliance:** Partial. **Current recommendations**: Same as in C.1.a through C.1.e.
C.1.g	Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.	**Current findings on previous recommendation:** **Recommendation June 2007:** Address and correct factors related to low compliance. **Findings:** PSH used the DMH WRP Observation Monitoring Form to assess its compliance with this requirement of the EP (May to October 2007). The facility reviewed variable samples of the total number of 7-day, 14-day, quarterly and annual WRPCs. The following outlines the mean sample size and compliance rate for each conference:

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><th>WRPC</th><th>Mean S%</th><th>Mean %C</th></tr>
<tr><td>7-day</td><td>12</td><td>5</td></tr>
<tr><td>14-day</td><td>14</td><td>3</td></tr>
<tr><td>Quarterly</td><td>23</td><td>1</td></tr>
<tr><td>Annual</td><td>13</td><td>0</td></tr>
</table>

PSH reports that the recent implementation of WaRMSS (September and October 2007) is expected to have a positive impact on the scheduling and coordination of assessments and tram meetings over the next three to six months.

Compliance:
Partial.

Current recommendations:
1. Continue to monitor this requirement using process observation.
2. Address and correct factors related to low compliance.
</td>
</tr>
<tr>
<td>C.1.h</td>
<td>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</td>
<td>Current findings on previous recommendations:

Recommendations 1-4, June 2007:
1. Address and correct the deficiencies regarding core memberships of the WRPT.
2. Address and correct deficiencies regarding attendance by core members.
3. Continue to monitor the core membership of the WRPTs.
4. Continue and ensure accuracy of monitoring the attendance by core members in the WRPCs.

Findings:
PSH has continued to collect data on this process using the WRP Attendance Monitoring Form. The facility reports that in November</td>
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2007, a mechanism within the current Plato software system was developed to provide data regarding core membership and attendance by core members. The facility recognizes that lack of coordination between the teams and staffing resources remain barriers to attendance at WRPCs. Beginning in November, 2007, the facility should be able to analyze patterns and trends by teams to develop action plans that improve compliance.

Using the WRP Attendance Monitoring Form, the facility reviewed monthly samples that varied from 9% to 26% (May to October 2007) of the total number of conferences due for the month. Based on these samples, the facility reported the following mean compliance rates regarding team attendance by each discipline (PSH did not present data regarding attendance by the individual):

Psychiatrist	89
Psychologist	66
Social Worker	76
Rehabilitation Therapist	68
Registered Nurse	42
Psychiatric Technician	36

The above data show that, overall, the attendance rates have not changed significantly compared to the last review.

Compliance:
Partial.

Current recommendations:
1. Develop and implement database that includes information regarding the core membership of all teams in the facility.
2. Regularly monitor the attendance by core members, including the individuals, in the WRPCs.

<table>
<tr><td></td><td></td><td>3. Address and correct the deficiencies regarding core membership and attendance by core members.</td></tr>
<tr><td>C.1.i</td><td>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</td><td>Current findings on previous recommendation:

Recommendation, June 2007:
Ensure consistent compliance with this requirement.

Findings:
PSH has data regarding the case loads of core team members during the months of May to October 2007. The data show that the case loads exceed plan requirements for psychologists and rehab therapists on the admission units, and for psychologists, rehab therapists and psychiatrists on the non-admission units.

The following tables summarize the staff FTE/individual ratios in admission and non-admission units:

<table>
<tr><th colspan="8">Admissions WRPTs (expected ratios 1:15)</th></tr>
<tr><td></td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Mean</td></tr>
<tr><td>1. MDs</td><td>1:14</td><td>1:16</td><td>1:14</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:15</td></tr>
<tr><td>2. PhDs</td><td>1:15</td><td>1:16</td><td>1:15</td><td>1:18</td><td>1:19</td><td>1:19</td><td>1:17</td></tr>
<tr><td>3. SWs</td><td>1:14</td><td>1:14</td><td>1:15</td><td>1:15</td><td>1:15</td><td>1:14</td><td>1:15</td></tr>
<tr><td>4. RTs</td><td>1:14</td><td>1:17</td><td>1:15</td><td>1:16</td><td>1:16</td><td>1:16</td><td>1:16</td></tr>
<tr><td>5. RNs</td><td>1:6</td><td>1:6</td><td>1:6</td><td>1:6</td><td>1:6</td><td>1:6</td><td>1:6</td></tr>
<tr><td>6. PTs</td><td>1:3</td><td>1:3</td><td>1:3</td><td>1:3</td><td>1:3</td><td>1:3</td><td>1:3</td></tr>
</table>
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<table>
<tr><th colspan="8">Non-Admission WRPTs (average expected ratios 1:25)</th></tr>
<tr><td></td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Mean</td></tr>
<tr><td>1. MDs</td><td>1:29</td><td>1:30</td><td>1:30</td><td>1:31</td><td>1:28</td><td>1:26</td><td>1:29</td></tr>
<tr><td>2. PhDs</td><td>1:57</td><td>1:57</td><td>1:57</td><td>1:60</td><td>1:41</td><td>1:41</td><td>1:52</td></tr>
<tr><td>3. SWs</td><td>1:23</td><td>1:23</td><td>1:23</td><td>1:24</td><td>1:25</td><td>1:24</td><td>1:24</td></tr>
<tr><td>4. RTs</td><td>1:37</td><td>1:36</td><td>1:32</td><td>1:32</td><td>1:29</td><td>1:29</td><td>1:33</td></tr>
<tr><td>5. RNs</td><td>1:8</td><td>1:8</td><td>1:8</td><td>1:8</td><td>1:8</td><td>1:8</td><td>1:8</td></tr>
<tr><td>6. PTs</td><td>1:3</td><td>1:3</td><td>1:3</td><td>1:3</td><td>1:3</td><td>1:3</td><td>1:3</td></tr>
</table>

The facility reports that the recent wage increase approved by the Department of Mental Health is expected to improve recruitment efforts and compliance with this requirement. For example, the Psychology Department has seen a net increase of 10 psychologists over the last six months. In addition, several psychiatrists have reportedly expressed interest in employment but are awaiting implementation of the official wage prior to finalizing the application process.

Compliance:
Partial.

Current recommendations:
1. Same as in C.1.h.
2. Ensure consistent compliance with this requirement.
</td>
</tr>
<tr>
<td>C.1.j</td>
<td>Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2007:
Same as in C.1.a through C.1.f.

Findings:
Same as in C.1.a through C.1.f.
</td>
</tr>
</table>

		Compliance: Partial. **Current recommendations**: Same as in C.1.a through C.1.f.

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)		
	Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:	**Methodology:** <u>Interviewed</u>: 1. Four individuals (TA, Program 4, Unit 35; PS, Program 4, Unit 34; LEF, Program 4, Unit 36; and MH) 2. A. Suvanaket, RN, Nurse 3. Andre Bryant, Substance Abuse Services Coordinator. 4. Araceli Alcantara-Liu, MD, Psychiatrist 5. Bermudez Pablo, RN, Nurse 6. Brenda Schell, PT 7. Coqueece Hibinski, PT 8. David Haimson, PhD, Chief of Psychology 9. Denise Armas-Carl, PT 10. Diane Ryssel 11. Dominique Kinney, PhD, Neuropsychologist 12. Don Brown, RN, Nurse 13. Fred Wolfner, Program Director, Enhancement Services 14. Gari-Lyn Richardson, Director, Standards Compliance 15. George Christison, MD, Acting Chief of Professional Education. 16. George Proctor, MD, Psychiatrist 17. Georgiana Vinson, RN, Standards Compliance 18. J. Williams, RT, Rehabilitation Therapist 19. Jana Larmer, PsyD, Standards Compliance Psychologist 20. Jeff Chambliss, PT 21. Jim Pollard, Program Director 22. Joanne Parcel, PT 23. Jonas Lumas, Acting Unit Supervisor 24. Joseph Allen, PT, Psychiatric Technician 25. Joseph Malancharuvil, PhD, APBB, Clinical Administrator 26. Keri Patrick Steele 27. Octavio Luna, Executive Director 28. M. Kesterson, PT, Psychiatrist Technician

		29. Maria Castillo, RN, Nurse 30. Melanie Byde, PhD, Mall Director 31. Michael Owen, PhD, Psychologist 32. Michelle Sefers, PT, PBS 33. Neomi Sabio, RN, Nurse 34. P. Cawunder, PhD, Psychologist 35. Paul McMahon, PhD, Psychologist 36. R. Crane, LCSW, Social Worker 37. Renata Geyer, LCSW, Social Worker 38. Roger Combs, RT, Rehabilitation Therapist 39. Sandra Brizuela, PT, Psychiatric Technician 40. Steven Mauer, MD, Chief of Medical Staff. 41. Susan Velasquez, PhD, Psychologist 42. Theresa Doal, PT 43. W. Saeed, MD, Psychiatrist 44. Wadsworth Murad, MD, Acting Chief of Psychiatry. <u>Reviewed</u>: 1. The charts of the following 84 individuals: AJ, AA, AAS, AJP, AKS, ALO, AMG, AR, AYH, BLC, BLE, BMS, CC, CCD, CH, CH-2, CK, CRM, CSC, DAC, DD, DEM, DM, DR, DS, EA, EF, EJ, ES, FL, GG, GJP, HHD, HRB, IA, JAC, JBW, JH, JJJ, JM, JML, JO, JR, KA, KC, KH, KJ, KLK, LC, LGC, MA, ME, MEB, MH, ML, MP, MS, NB, NL, NM, OC, OM, OVM, PAB, QDB, RA, RAD, RAR, RD, RR, RVB, SB, SBP, SEB, SF, SKG, SLT, TA, TAB, WJB, WML, WMP, WTS, and YT 2. AD 15.42, Wellness and Recovery Plan (November 2007) 3. PSH Trigger Action Sheet regarding Non-Adherence to WRP 4. Case Formulation Module Training Topics 5. Foci & Objectives Module Training Topics 6. PSH Discharge Planning and Community Integration Training Module 7. DMH WRP Observation Monitoring Form 8. DMH WRP Observation Monitoring Form Instructions 9. DMH WRP Observation Monitoring summary data (May to October

		2007) 10. DMH WRP Chart Auditing Form 11. DMH WRP Chart Auditing Form Instructions 12. DMH WRP Chart Auditing summary data (May to October 2007) 13. DMH WRP Clinical Chart Auditing Form 14. DMH WRP Clinical Chart Auditing Form Instructions 15. DMH WRP Clinical Chart Auditing summary data (May to October 2007) 16. PSH Substance Abuse checklist 17. PSH Substance Abuse checklist summary data (May to October 2007) 18. Substance Abuse Course Outline 19. DMH Mall Alignment Checklist 20. DMH Mall Alignment summary data (August to October 2007) 21. Credentialing/Privileging for Substance Abuse 22. DMH Integrated Assessment: Social Work Section 23. DMH Integrated Assessment: Social Work Section--Instructions 24. DMH Integrated Rehabilitation Therapy Assessment 25. DMH Integrated Rehabilitation Therapy Assessment--Instructions 26. Focus 5 Curriculum Training Roster for Providers 27. Integrated Assessment: Psychology Section 28. Integrated Assessment: Psychology Section--Instructions. 29. List of Activities Outside Mall Hours 30. List of Completed DSM-IV-TR Checklist 31. List of Enrichment Activities 32. List of Individuals Who Met Discharge Criteria and Are Still Hospitalized 33. List of Trigger Items by Individuals 34. List Verifying Staff Competency for Specific Mall Groups 35. Mall Hours of Participation by Individuals 36. Mall Hours Served by Administrative/Support Staff 37. Mall Hours Served by Discipline 38. Missed Appointment List

		39. Nursing Integrated Assessments 40. PSH Progress Report 41. PSH Resource Catalog 42. PSR Mall Curricula 43. PSR Mall Hours of Service by Administrative and Support Staff 44. PSR Mall Hours of Service by Discipline 45. PSR Mall Schedule 46. Verification of Competency for Providing Substance Abuse Groups 47. WRP Mall Alignment Check Protocol <u>Observed</u>: 1. WRPC (Program VI, unit EB-01) for 14-day review of SKG 2. WRPC (Program VI, unit EB-01) for monthly review of SDR 3. WRPC (Program IV, unit 36) for quarterly review of KH 4. WRPC (Program I, unit EB-11) for quarterly review of JL 5. WRPC (Program VIII, unit 25) for BDM 6. WRPC (Program IV, unit 34) for DLG 7. WRPC (Program VI, unit EB-02) for AV 8. WRPC for JL 9. PSR Mall group: Smoking Cessation: You Can Quit 10. PSR Mall group: 64 Ways to Non-Violence (Program III, unit 31)
C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Same as in C.1.a through C.1.f. **Findings:** Same as in C.1.a through C.1.f. **Recommendation 2, June 2007:** Continue and strengthen WRP training that focuses on the process of engaging the individual in providing substantive input.

Findings:
As mentioned in C.1.a under Findings for Recommendation 2, PSH has provided training based on the MSH Engagement module. This training was implemented in October 2007. According to PSH, the delay in implementation occurred due to lack of resources to provide the training. Currently, this training consists of a 90-minute course held three times a week in a classroom setting. Additionally, the psychologist instructor/mentor is attending team conferences and providing feedback on WRP observation audits specifically related to engaging the individual in providing substantive input into the WRP process. PSH data regarding WRPT members who have completed this training were presented in C.1.a.

Recommendation 3, June 2007:
Continue observation monitoring of this requirement and identify total target population and sample sizes.

Findings:
To assess compliance with this requirement, PSH used the DMH Observation Monitoring Form (May to October 2007). The facility reviewed variable samples of the total number of 7-day, 14-day, quarterly and annual WRPCs. As mentioned earlier, the facility has yet to implement the 30-day WRPC in non-admission units. The following outlines the mean sample size and compliance rate for each conference. PSH did not provide data analysis regarding specific areas of low compliance.

WRPC	Mean S%	Mean %C
7-day	12	2
14-day	14	0
Quarterly	23	1
Annual	13	0

		The facility identified the lack of training/mentoring resources to be the main barrier to compliance. As mentioned in C.1.a, PSH has a plan to use the senior clinician positions, once they are in place, as additional resources to train and mentor staff. **Other findings:** As mentioned in C.1.a, the monitor attended four WRPCs. In general, there was evidence that WRPT members were respectful of the individuals and made a sincere effort to elicit the individual's input. However, there were significant process deficiencies that were outlined in C.1.a. These deficiencies indicate that the current WRP training must be intensified and expanded to include ongoing feedback to the teams in order to achieve substantial compliance with this requirement. **Compliance:** Partial. **Current recommendations**: 1. Continue and strengthen WRP training that focuses on the process of engaging the individual in providing substantive input. 2. Continue observation monitoring of this requirement based on a 20% sample and provide data analysis regarding specific areas of low compliance and corrective actions.
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of	**Current findings on previous recommendations:**

	admission;	**Recommendation 1, June 2007:** Continue chart audits to assess compliance. **Findings:** PSH used the DMH WRP Chart Auditing Form to assess compliance. The facility reviewed an average sample of 9% of the initial WRPs due by month (May to October 2007). The mean compliance rate was 98%. **Recommendation 2, June 2007:** Address and correct factors related to low compliance. **Findings:** The facility reported a compliance rate in excess of 90%. **Other findings:** This monitor reviewed the charts of 12 individuals (AYH, JML, TAB, CRM, AMG, SB, CH, SKG, SF, EA, WJB and SEB). The reviews showed compliance in ten charts and non-compliance in one (JML). One individual (WJB) was admitted prior to implementation of the AWRP. **Compliance:** Substantial. **Current recommendations**: Continue chart audits to assess compliance based on at least a 20% sample.
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue chart audits to assess compliance and identify total target population and sample sizes.

		Findings: Using the DMH WRP Chart Auditing Form, PSH facility reviewed an average sample of10% of the master WRPs due by month (May to October 2007). The mean compliance rate was 72%. **Recommendation 2, June 2007:** Address and correct factors related to low compliance. **Findings:** PSH identified the high admission rate as the main barrier to compliance. The average length of stay is currently less than 60 days on admission units. The facility plans to open another admission unit as soon as staffing resources become available and continue to provide training and assistance to admission teams on how to use the new WaRMSS computer program. This program was implemented on the admission units starting at the end of September and has reportedly facilitated completion of the WRPCs as scheduled. **Other findings:** Reviewing the above-mentioned 12 charts, this monitor found compliance in 10 charts and non-compliance in one (SB). One individual (WJB) was admitted prior to implementation of the AWRP. **Compliance:** Partial. **Current recommendations**: 1. Continue chart audits to assess compliance. 2. Address and correct factors related to low compliance.
C.2.b.iii	therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every	**Current findings on previous recommendations:**

	30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.	**Recommendation 1, June 2007:** Align AD #15.42 with the DMH WRP Manual regarding requirements for timely completion of WRP reviews. **Findings:** PSH has implemented this recommendation. AD #15.42, Wellness and Recovery Plan has been revised in November 2007 and aligned with the requirements for the timely completion of WRP reviews. **Recommendation 2, June 2007:** Continue chart audits to assess compliance and identify total target population and sample sizes. **Findings:** PSH used the DMH WRP Chart Auditing Form (May to October 2007) to assess compliance with this requirement. The facility reviewed variable samples of the total number of 14-day, quarterly and annual WRP reviews. As mentioned earlier, the facility has yet to implement the 30-day WRP review in non-admission units. The following outlines the mean sample size and compliance rate for each review. PSH did not provide data analysis regarding specific areas of low compliance. **WRP Review** / **Mean S%** / **Mean %C** 14-Day / 15 / 1 Quarterly / 22 / 0 Annual / 6 / 0 **Recommendation 3, June 2007:** Address and correct factors related to low compliance. **Findings:** PSH reported that many conferences were being held more or less than one day of the required date resulting in low compliance. The facility

		did not report a plan to correct this matter. **Other findings:** Reviewing the above-mentioned 12 charts, this monitor found compliance in 10 charts (AYH, JML, TAB, CRM, AMG, SB, CH, SF, EA and SEB) and non-compliance in two (SKG and WJB). **Compliance:** Partial. **Current recommendations**: 1. Implement the required WRP conference schedule on all teams, including 30-day reviews. 2. Continue chart auditing, ensure a 20% sample and provide data analysis regarding specific areas of low compliance with corrective actions.
C.2.c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue and strengthen training of WRPTs to ensure that: a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization address all identified needs of the individual in the above domains. **Findings:** PSH has yet to implement this recommendation. As mentioned in C.1.a, the facility plans to implement the modules developed by MSH regarding Case Formulation and Foci/Objectives/Interventions after necessary training has been completed regarding Team Leadership and Engagement. PSH has prioritized training on Team Leadership and

		Engagement as a foundation for subsequent training on the Case Formulation, Foci, Objectives and Interventions. The facility has updated the MSH Case Formulation Module to enhance alignment with EP requirements. **Recommendation 2, June 2007:** Continue to assess compliance with this requirement using the WRP Clinical Chart Auditing Form and the checklists regarding Cognitive Disorders, Seizure Disorders and Substance Abuse Disorders. **Findings:** Using the DMH WRP Clinical Chart Auditing Form, PSH reviewed an average sample of 19% of the quarterly and annual WRPs due per month (May to October 2007). The facility reported a mean compliance rate of 8% regarding this requirement. PSH also used the Substance Abuse Checklist to assess compliance in the area of substance use disorders. The facility's data are presented in C.2.o. The facility did not provide data from the tools regarding Cognitive Disorders and Seizure Disorders. However, the Clinical Chart Audit data are sufficient to address these disorders. **Recommendation 3, June 2007:** Develop and implement operational instructions and inter-rater reliability checks regarding the use of the checklists. **Findings:** PSH has implemented this recommendation. The Substance Abuse Checklist has been finalized with instructions and submitted for statewide review. **Recommendation 4, June 2007:** Ensure that current monitoring addresses the needs of individuals

		identified to be at risk for falls. **Findings:** This area is monitored as part of the Key Indicator/Trigger system. **Recommendation 5, June 2007:** Address and correct factors related to low compliance with this requirement. **Findings:** PSH reported that low compliance was related to lack of training and staff resources, particularly on the non-admission units. The facility's plan includes providing training on the Case Formulation, Foci and Objectives and Interventions and Mall Integration as listed in previous cells. **Other findings:** This monitor reviewed the charts of individuals suffering from a variety of cognitive impairments and seizure disorders. The reviews indicate that treatment and rehabilitation services still ignore some important needs of these individuals. The following are chart examples in each category: 1. Individuals diagnosed with cognitive impairments: a. The WRPs do not include focus of hospitalization or objectives/interventions for individuals diagnosed with R/O Dementia (AYH), Mild Mental Retardation (SBP, RA, KC and RAD), Cognitive Disorder, NOS (SLT and CH-2) and Borderline Intellectual Functioning (DR). b. The WRP lists objectives that are not attainable and /or measurable for an individual who has a diagnosis of Vascular Dementia (WMP). c. The WRPs (and the corresponding psychiatric progress notes)

		do not track the status of cognition for individuals diagnosed with R/O Mental Retardation (CH-2), Vascular Dementia (JAC), Cognitive Disorder, NOS (SLT) and Mild Mental Retardation (SBP and RAD). d. The interventions do not include an assessment of the possible adverse effect of regular treatment with high-risk medications (e.g. phenytoin and benztropine) on individuals diagnosed with Mental Retardation, Mild (RA) and Cognitive Disorder, NOS (SLT). e. In general, the present status section of the WRP does not address the status of the individual's cognitive dysfunction. 2. Individuals diagnosed with seizure disorders: a. The WRPs do not include a specific diagnosis regarding the type of seizure disorder (JM, NM, AAS, AA, JBW, RAR and CCD). b. The WRPs include objectives that are not attainable for the individuals, focusing on being free from seizure activity or side effects of treatment (JBW, JM, NM and AAS) c. The WRPs contain objectives that are vague and generic without documentation of the relevance to the individual's needs (AAS, JBW, RAR and CCD). d. The present status section of the WRP does not address the status of the individual's seizure activity during the previous interval in almost all cases. e. The WRPs do not include objectives/ interventions to assess the risks of treatment with older anticonvulsant medications and to minimize its impact on the individual's behavior and cognitive status. Examples include individuals receiving phenytoin (JM, NM, AAS, AKS, AA, JBW, RAR and CCD) or phenobarbital (CH-2). Some of these individuals also suffer from documented cognitive impairment, which increases the risk of this treatment (CH-2).

		See monitor's findings in C.2.o regarding individuals suffering from substance use disorders. **Compliance:** Partial. **Current recommendations**: 1. Continue and strengthen training of WRPTs to ensure that: a. The case formulation includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains, and b. Foci of hospitalization address all identified needs of the individual in the above domains. 2. Monitor this requirement using the Clinical Chart Auditing Form and the Substance Abuse Checklist, ensure a 20% sample and provide data analysis regarding specific areas of low compliance and corrective actions. 3. Ensure that corrective actions address the monitor's findings of deficiency listed above.
C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	**Compliance:** Partial.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue and strengthen training of the WRPTs to ensure that the case

		formulation adequately addresses the requirements in C.2.d. **Findings:** As mentioned above, the Case Formulation Training Module will be implemented after Team Leader Training has been completed. The facility reports that all members of the WRPTs in Programs I and VII (#20 teams) have had WaRMSS training with an emphasis on the requirements for completion of the present status section of the case formulation. All other teams will receive this training in the upcoming months. **Recommendation 2, June 2007:** Continue monitoring of this requirement using the Clinical Chart Auditing Form based on a defined target population and a review of a 20% sample. **Findings:** PSH used the DMH WRP Clinical Chart Auditing Form to assess compliance with this requirement (May to October 2007). The facility reviewed an average sample of 19% of the quarterly and annual WRPs due per month. The facility reported mean compliance rates of 0% for this requirement. The mean compliance rates for requirements in C.2.d.ii through C.2.d.vi are listed in each corresponding sub-cell. PSH recognized that training using the Case Formulation Module is needed and plans to start this training based on the MSH Module in the upcoming months. **Recommendation 3, June 2007:** Address and correct factors related to low compliance. **Findings:** Same as above.

		Other findings: Chart reviews and WRPCs attended by this monitor indicate that PSH has made some progress in ensuring that the case formulations are completed in the 6-p format. However, the content of most of these formulations shows that the facility has yet to make progress regarding the following general deficiencies: 1. The present status sections do not include sufficient review and analysis of important clinical events that require modifications in WRP interventions. The most significant deficiencies involve needed information in the reviews of: a. Use of restrictive interventions; b. Clinical progress regarding a variety of disorders and high risk behaviors; and c. Clinical progress towards individualized discharge criteria. 2. The linkages within different components of the formulations are often missing. 3. The formulations contain inadequate analysis of assessments and derivation of hypothesis regarding the individual's diagnosis, differential diagnosis, treatment, rehabilitation and enrichment needs. 4. There is inadequate linkage between the material in the case formulations and other key components of the WRP (e.g. foci of hospitalization, life goals, objectives and interventions). These deficiencies must be corrected in order to achieve substantial compliance with this requirement. **Current recommendations:** 1. Continue and strengthen training of the WRPTs to ensure that the case formulations adequately address the requirements in C.2.d. and correct the above deficiencies outlined by this monitor. 2. Continue Clinical Chart auditing, ensure a 20% sample and implement

		corrective actions regarding areas of low compliance.
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	0%
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;	0%
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	0%
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	1%
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	0%
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the	**Current findings on previous recommendation:**

<table>
<tr>
<td></td>
<td>staff will assist the individual to achieve his or her goals/objectives (interventions);</td>
<td>
Recommendation, June 2007:
Same as in C.2.c, C.2.f, C.2.g and C.2.o.

Findings:
Same as in C.2.c, C.2.f, C.2.g and C.2.o.

Other findings:
PSH used the DMH WRP Chart Auditing Form (May to October 2007) to assess compliance with this requirement. The facility reviewed variable samples of the total number of 7-day, 14-day, quarterly and annual WRP reviews. The following outlines the mean sample size and compliance rate for each review. PSH did not provide data analysis regarding specific areas of low compliance.

<table>
<tr><th>WRP Review</th><th>Mean S%</th><th>Mean %C</th></tr>
<tr><td>7-Day</td><td>14</td><td>0</td></tr>
<tr><td>14-Day</td><td>15</td><td>0</td></tr>
<tr><td>Quarterly</td><td>22</td><td>1</td></tr>
<tr><td>Annual</td><td>6</td><td>0</td></tr>
</table>

Compliance:
Partial.

Current recommendations:
1. Same as in C.2.c, C.2.f, C.2.g and C.2.o.
2. Continue chart audits, ensure a 20% sample and provide data analysis regarding areas of low compliance and corrective actions.
</td>
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<tr>
<td>C.2.f</td>
<td>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in</td>
<td>Please see sub-cells for compliance findings.</td>
</tr>
</table>

<table>
<tr><td></td><td>the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</td><td></td></tr>
<tr><td>C.2.f.i</td><td>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</td><td>Current findings on previous recommendations:

Recommendation 1, June 2007:
Continue and strengthen training of WRPTs to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual.

Findings:
PSH has yet to implement this recommendation.

Recommendation 2, June 2007:
Continue monitoring using the Clinical Chart Auditing and Process Observation Forms and ensure a 20% sample of a defined target population.

Findings:
PSH used the DMH WRP Chart Auditing Form (May to October 2007) to assess compliance with this requirement. The facility reviewed variable samples of the 7-day, 14-day, quarterly and annual WRP reviews. The following outlines the mean sample size and compliance rate for each review. PSH did not provide data analysis regarding specific areas of low compliance.

<table>
<tr><th>WRP review</th><th>Mean S%</th><th>Mean %C</th></tr>
<tr><td>7-day</td><td>10</td><td>0</td></tr>
<tr><td>14-day</td><td>15</td><td>0</td></tr>
<tr><td>Quarterly</td><td>22</td><td>1</td></tr>
<tr><td>Annual</td><td>6</td><td>0</td></tr>
</table>
</td></tr>
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The facility also used the DMH WRP Observation Monitoring Form (May to October 2007) to assess compliance with this requirement. The facility reviewed variable samples of the total number of 7-day, 14-day, quarterly and annual WRPC. The following outlines the mean sample size and compliance rate for each conference. PSH did not provide data analysis regarding specific areas of low compliance.

WRPC	Mean S%	Mean %C
7-day	12	1
14-day	14	0
Quarterly	23	0
Annual	13	0

Recommendation 3, June 2007:
Address and correct factors related to low compliance with this requirement.

Findings:
Same as above.

Other findings:
This monitor reviewed the charts of five individuals (PAB, CSC, BLC, RVB and SEB). The review showed non-compliance in four charts (CSC, BLC, RVB and SEB) and compliance in one (PAB).

Compliance:
Partial.

Current recommendations:
1. Continue and strengthen training of WRPTs to ensure that objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual.

<table>
<tr><td></td><td></td><td>2. Continue monitoring using the Clinical Chart Auditing and Process Observation Forms, ensure a 20% sample and provide data analysis regarding specific areas of low compliance and corrective actions.</td></tr>
<tr><td>C.2.f.ii</td><td>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);</td><td>Current findings on previous recommendation:

Recommendation, June 2007:
Same as above.

Findings:
Same as above.

PSH used the DMH WRP Chart Auditing process (May to October 2007) to assess compliance. The following outlines the mean sample size and compliance rate for each type of WRP review. PSH did not provide data analysis regarding specific areas of low compliance.

<table>
<tr><th>WRP Review</th><th>Mean S%</th><th>Mean %C</th></tr>
<tr><td>7-day</td><td>10</td><td>2</td></tr>
<tr><td>14-day</td><td>15</td><td>3</td></tr>
<tr><td>Quarterly</td><td>22</td><td>4</td></tr>
<tr><td>Annual</td><td>6</td><td>0</td></tr>
</table>

Other findings:
This monitor reviewed the charts of five individuals (PAB, CSC, BLC, RVB and SEB). The review showed non-compliance in four charts (PAB, BLC, RVB and SEB) and compliance in one (CSC).

Compliance:
Partial.

Current recommendations:
1. Continue and strengthen training of WRPTs to ensure that</td></tr>
</table>

<table>
<tr><td></td><td></td><td>objectives and interventions are implemented in accordance with the requirements in the DMH WRP manual.
2. Continue chart auditing, ensure a 20% sample and provide data analysis regarding specific areas of low compliance and corrective actions.</td></tr>
<tr><td>C.2.f.iii</td><td>write the objectives in behavioral, observable, and/or measurable terms;</td><td>Current findings on previous recommendation:

Recommendation, June 2007:
Same as above.

Findings:
Same as above.

PSH used the DMH WRP Chart Auditing process (May to October 2007) to assess compliance. The following outlines the mean sample size and compliance rate for each type of WRP review. PSH did not provide data analysis regarding specific areas of low compliance. The facility anticipates that sampling will improve for all conferences when the teams are using WaRMSS for conference documentation.

<table>
<tr><th>WRP Review</th><th>Mean S%</th><th>Mean %C</th></tr>
<tr><td>7-day</td><td>10</td><td>5</td></tr>
<tr><td>14-day</td><td>15</td><td>2</td></tr>
<tr><td>Quarterly</td><td>22</td><td>3</td></tr>
<tr><td>Annual</td><td>6</td><td>0</td></tr>
</table>

Other findings:
This monitor reviewed the charts of five individuals (PAB, CSC, BLC, RVB and SEB) and found non-compliance in all charts.

Compliance:
Partial.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendations:
Same as above.</td></tr>
<tr><td>C.2.f.iv</td><td>include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;</td><td>Current findings on previous recommendation:

Recommendation, June 2007:
Same as above.

Findings:
Same as above.

PSH used the DMH WRP Chart Auditing process (May to October 2007) to assess compliance. The following outlines the mean sample size and compliance rate for each type of WRP review. PSH did not provide data analysis regarding specific areas of low compliance.

<table>
<tr><th>WRP Review</th><th>Mean S%</th><th>Mean %C</th></tr>
<tr><td>7-day</td><td>10</td><td>0</td></tr>
<tr><td>14-day</td><td>15</td><td>0</td></tr>
<tr><td>Quarterly</td><td>22</td><td>6</td></tr>
<tr><td>Annual</td><td>6</td><td>0</td></tr>
</table>

Other findings:
This monitor reviewed the charts of five individuals (PAB, CSC, BLC, RVB and SEB). The review showed compliance in three charts (CSC, BLC and RVB), partial compliance in one (SEB) and noncompliance in one (PAB).

Compliance:
Partial.</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendations:
Same as above.</td></tr>
<tr><td>C.2.f.v</td><td>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</td><td>Current findings on previous recommendation:

Recommendation, June 2007:
Same as above.

Findings:
Same as above.

PSH used the DMH WRP Chart Auditing process (May to October 2007) to assess compliance. The following outlines the mean sample size and compliance rate for each type of WRP review. PSH did not provide data analysis regarding specific areas of low compliance.

<table>
<tr><th>WRP Review</th><th>Mean S%</th><th>Mean %C</th></tr>
<tr><td>7-day</td><td>10</td><td>0</td></tr>
<tr><td>14-day</td><td>15</td><td>0</td></tr>
<tr><td>Quarterly</td><td>22</td><td>3</td></tr>
<tr><td>Annual</td><td>6</td><td>0</td></tr>
</table>

Other findings:
This monitor's review of the above-mentioned five charts showed compliance in four charts (PAB, CSC, BLC and SEB) and non-compliance in one (RVB).

Compliance:
Partial.

Current recommendations:
Same as above.</td></tr>
</table>

C.2.f.vi	implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Correct factors related to inadequate scheduling by the WRPTs, incomplete reporting of hours scheduled on the WRP, discrepancy between WRP and MAPP data and inadequate participation by individuals. **Findings:** PSH has made some progress towards implementation of this requirement. In addition, the recently implemented WaRMSS program has ensured that the WRP cannot be finalized until each focus of treatment has an active treatment intervention. The facility reports that barriers towards full implementation of this requirement continue to be lack of resources, particularly on the non-admission units as well as lack of training resources. PSH's plan to address these barriers is the same as that described in previous cells. **Recommendation 2, June 2007:** Continue efforts to monitor hours of active treatment (scheduled and attended). **Findings:** PSH presented information regarding the number of individuals who were scheduled for Mall activities and are attending at least one group in the PSR Mall. The data are based on a review of a 100% sample of the individuals' census during October 2007. The following tables summarize the facility's data. The number of individuals reviewed (n) is larger than the census (N) due to the number of admissions and discharges per month.

	Scheduled hours (number of individuals by category)	Attended hours (number of individuals by category)
N	1517	1517
n	1572	1572
%S	100	100
Hours:		
0-1	27	38
2-5	29	70
6-10	85	213
11-15	81	829
16-19	475	422
20+	872	0

Hours attended differ from hours scheduled because some individuals are not attending as scheduled and thus fall into a different row with fewer hours.

Other findings:
This monitor reviewed six charts (CSC, BLC, RVB, SEB, MEB and QDB) to determine the number of active treatment hours that were scheduled as per the most recent WRP and the number of hours that were scheduled and attended per MAPP. The review showed the following:

1. The WRPs still generally fail to schedule and identify the required number of hours;
2. Inconsistency still exists between WRP and MAPP data regarding scheduled hours and actual hours attended; and
3. The individuals do not attend the required number of active treatment hours but positive trend is noted compared to the last review both in the hours scheduled and the hours attended (per

<table>
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<td>MAPP).

<table>
<tr><th>Individual</th><th>Scheduled hours (WRP)</th><th>Scheduled hours (MAPP)</th><th>Attended hours (MAPP)</th></tr>
<tr><td>CSC</td><td>8</td><td>20</td><td>17</td></tr>
<tr><td>BLC</td><td>3</td><td>20</td><td>16</td></tr>
<tr><td>RVB</td><td>unspecified</td><td>20</td><td>15</td></tr>
<tr><td>SEB</td><td>3</td><td>21</td><td>16</td></tr>
<tr><td>MEB</td><td>13</td><td>20</td><td>15</td></tr>
<tr><td>QDB</td><td>15</td><td>18</td><td>14</td></tr>
</table>

Compliance:
Partial.

Current recommendations:
1. Correct factors related to inadequate documentation of scheduled hours on the WRPs and the discrepancies between WRP and MAPP data.
2. Continue to monitor hours of active treatment (scheduled and attended) and provide data analysis and corrective actions to ensure that individuals attend the required hours.</td>
</tr>
<tr>
<td>C.2.f.vii</td>
<td>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</td>
<td>Current findings on previous recommendation:

This requirement is not applicable to PSH. The facility is unable to legally allow individuals to participate in community treatment opportunities unless accompanied by a CDCR Correctional Officer.</td>
</tr>
<tr>
<td>C.2.f.viii</td>
<td>ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State</td>
<td>Current findings on previous recommendations:

Recommendation 1, June 2007:
Finalize instructions to ensure inter-rater reliability regarding the Mall</td>
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	hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.	Alignment Checklist. **Findings:** A tool has been developed and approved for statewide use. However, PSH reports that based on the target population this audit would require five hours to complete by the auditor and 3.5 full time auditors to accomplish the task at the facility. The statewide Mall directors' workgroup is currently revising the tool to enable adequate monitoring in a reasonable timeframe. Until that can be accomplished, a random sample size of 20 audits per month stratified by Mall will be used. Although this sample size is very low, it is anticipated that this mechanism will be sufficient to address this requirement. **Recommendation 2, June 2007:** Use the finalized Mall Alignment Checklist to monitor this requirement based on a 20% sample of a defined target population. **Findings:** PSH used the DMH Mall Alignment Checklist to assess compliance (August to October 2007) based on an average sample size of approximately 3% of the number of WRPs due by month starting at the fourteenth day. The facility reported a mean compliance rate of 14%. The facility assessed that the main reasons for the low compliance are the change in the Mall cycle and the difficulty in updating the WRPs (due to the lack of monthly conferences). **Recommendation 3, June 2007:** Implement electronic progress note documentation by all mall and individual therapy providers. **Findings:** PSH has yet to execute its plan of implementing progress notes at the second 14-day conference (42 days since admission and 28 days since

		attending individualized mall schedule after admission mall). According to the facility, implementation will occur starting December 1 throughout the hospital. **Recommendation 4, June 2007:** Implement mechanisms to ensure proper linkage between type and objectives of mall activities and objectives outlined in the WRP as well as documentation of this linkage. **Findings:** PSH has yet to implement this recommendation. The facility anticipates that the recent implementation of WaRMSS WRP and planned training on Foci/Objectives/Interventions and Mall Integration modules should facilitate compliance. **Other findings:** Reviewing the charts of six individuals (PAB, CSC, BLC, RVB, SEB and MEB), this monitor found non-compliance in three charts (BLC, RVB and MEB), compliance in two (PAB and CSC) and partial compliance in one (SEB). **Compliance:** Partial. **Current recommendations**: 1. Use the finalized Mall Alignment Checklist to monitor this requirement and provide data analysis regarding areas on low compliance and corrective actions. 2. Implement electronic progress note documentation by all mall and individual therapy providers. 3. Implement mechanisms to ensure proper linkage between type and objectives of mall activities and objectives outlined in the WRP as well as documentation of this linkage.

C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue and strengthen training to WRPTs to ensure that foci and objectives are reviewed and revised and that new interventions are developed and implemented as clinically needed. **Findings:** Same as in C.1.a (Recommendation 2), C.2.c (Recommendation 1) and C.2.f.i (Recommendation 1). **Recommendation 2, June 2007:** Monitor this requirement using both process observation and chart auditing. **Findings:** PSH used the previously mentioned DMH WRP Clinical Chart Auditing process to assess compliance. The facility reported a mean compliance rate of 1% with this requirement. PSH did not provide data analysis regarding specific areas of low compliance. In addition, PSH used the DMH Observation Monitoring process (May to October 2007). The following table summarizes the facility's data. PSH did not provide data analysis regarding specific areas of low

<table>
<tr>
<td></td>
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<td>compliance.

<table>
<tr><th>WRP Review</th><th>Mean S%</th><th>Mean %C</th></tr>
<tr><td>7-day</td><td>12</td><td>0</td></tr>
<tr><td>14-day</td><td>14</td><td>1</td></tr>
<tr><td>Quarterly</td><td>23</td><td>1</td></tr>
<tr><td>Annual</td><td>13</td><td>3</td></tr>
</table>

Recommendation 3, June 2007:
Address and correct factors related to low compliance.

Findings:
Same as above.

Other findings:
This monitor found non-compliance in all five charts reviewed (CSC, BLC, RVB, SEB and MEB).

Compliance:
Partial.

Current recommendations:
Monitor this requirement using both process observation and chart auditing and analyze and correct factors related to low compliance.</td>
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<tr>
<td>C.2.g.ii</td>
<td>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</td>
<td>Current findings on previous recommendations:

Recommendation 1, June 2007:
Same as above.

Findings:
Same as above.</td>
</tr>
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Recommendation 2, June 2007:
Revise current monitoring tool to include individuals whose functional status has improved.

Findings:
PSH has yet to address this recommendation.

Recommendation 3, June 2007:
Continue monitoring using process observation and chart audits based on a 20% sample of a defined target population.

Findings:
PSH used the DMH WRP Chart Auditing process (May to October 2007) to assess compliance. The following table outlines the mean sample size and compliance rate for each type of WRP review. PSH did not provide data analysis regarding specific areas of low compliance.

WRP Review	Mean S%	Mean %C
7-day	10	4
14-day	15	11
Quarterly	22	4
Annual	6	0

In addition, PSH used the DMH Observation Monitoring process (May to October 2007). The following table summarizes the facility's data. PSH did not provide data analysis regarding specific areas of low compliance.

WRP Review	Mean S%	Mean %C
7-day	12	1
14-day	14	1
Quarterly	23	1
Annual	13	1

		Recommendation 4, June 2007: Address and correct factors related to low compliance. Ensure that the present status section of individuals who experience restrictive interventions includes both circumstances of use and modifications of interventions to reduce the risk. **Findings:** As mentioned earlier, the facility provided training to 20 WRPTs in Programs I and VII (October 2007) on the use of the WaRMSS. The program involves completion of the present status section of the case formulation and has a specific folder to discuss changes in an individual's status in this section. **Other findings:** This monitor reviewed the charts of six individuals (GJP, KLK, DAC, OC, ML and WTS) who experienced the use of seclusion/restraints during this review period. This review showed that only one chart (KLK) included documentation in the present status section of the use of seclusion/restraints or the circumstances of such use. None of the charts included documentation of modification of treatment as a result of the use of seclusion/restraints. **Compliance:** Partial. **Current recommendations**: 1. Implement corrective actions to ensure: a. Review by the WRPTs of the use of seclusion/restraints and the circumstances related to such use; and b. Timely and appropriate modification of the WRPs in response to the review. 2. Continue to monitor this requirement using observation and chart

<table>
<tr><td></td><td></td><td>auditing and analyze and correct factors related to low compliance.
3. Revise current monitoring tool to include individuals whose functional status has improved.</td></tr>
<tr><td>C.2.g.iii</td><td>ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</td><td>Current findings on previous recommendations:

Recommendation 1, June 2007:
Continue and strengthen training to WRPTs to ensure consistent implementation of this requirement.

Findings:
PSH has developed a training module regarding Discharge Planning and Community Integration and has a plan to implement this training within the next review period.

Recommendation 2, June 2007:
Monitor this requirement using both process observation and chart audits based on a 20% sample of a defined target population.

Findings:
In addition, PSH used the DMH Observation Monitoring process (May to October 2007). This process is sufficient. The following table summarizes the facility's data. PSH did not provide data analysis regarding specific areas of low compliance.

<table><tr><th>WRP Review</th><th>Mean S%</th><th>Mean %C</th></tr><tr><td>7-day</td><td>12</td><td>6</td></tr><tr><td>14-day</td><td>14</td><td>3</td></tr><tr><td>Quarterly</td><td>23</td><td>0</td></tr><tr><td>Annual</td><td>13</td><td>0</td></tr></table>
Recommendation 3, June 2007:
Address and correct factors related to low compliance.</td></tr>
</table>

		Findings: Same as above. **Other findings:** This monitor reviewed the charts of five individuals (PAB, CSC, BLC, RVB and SEB). Only one chart (BLC) included specific and/or individualized learning-based outcomes that relate to the individual's profile of symptoms and functional needs. None of the charts included documentation in the present status section of the case formulation of the team's discussion of the individual's progress toward discharge. **Compliance:** Partial. **Current recommendations**: 1. Implement the training module regarding Discharge Planning and Community Integration. 2. Monitor this requirement using both process observation and chart auditing, and analyze and correct factors related to low compliance.
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Same as in C.2.g.i. **Findings:** Same as in C.2.g.i. **Recommendation 2, June 2007:** Same as in C.2.f.viii.

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<td></td>
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Findings:
Same as in C.2.f.viii.

Other findings:
In addition, PSH used the DMH Observation Monitoring process (May to October 2007). The following table summarizes the facility's data. PSH did not provide data analysis regarding specific areas of low compliance.

<table>
<tr><th>WRP Review</th><th>Mean S%</th><th>Mean %C</th></tr>
<tr><td>7-day</td><td>12</td><td>0</td></tr>
<tr><td>14-day</td><td>14</td><td>0</td></tr>
<tr><td>Quarterly</td><td>23</td><td>0</td></tr>
<tr><td>Annual</td><td>13</td><td>0</td></tr>
</table>

Reviewing the charts of the same five individuals listed above, this monitor found non-compliance in all charts.

Compliance:
Partial.

Current recommendations:
Monitor this requirement using both process observation and clinical chart auditing, and analyze and correct factors related to low compliance.
</td>
</tr>
<tr>
<td>C.2.h</td>
<td>Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.</td>
<td>
Current findings on previous recommendation:

Recommendation 1, June 2007:
Ensure that PSH has the required number of PBS teams.

Findings:
PSH does not have the required number of PBS teams. PSH has two full
</td>
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		teams and one team without a nurse team member. **Recommendation 2, June 2007:** Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans. **Findings:** PSH has approved the authority for facility psychologists to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates. The authority is reflected in AD #15.09 (October 22, 2007). However, the authority is yet to be included in the Nursing Policy manual. According to the PBS coordinator and the Chief of Psychology, the Nursing Coordinator has accepted the AD and is looking into making the necessary changes in the Nursing Policy manual. **Recommendations 3-4, June 2007:** • Ensure that all staff implement PBS plans and collect reliable and valid outcome data. • Provide competency-based training to all staff in PBS procedures. **Findings:** This monitor's review of three PBS plans (HHD, ME, and JR) showed that PBS staff trained and certified staff who were responsible for implementing the program and collected fidelity data to ensure that the plan was implemented with a high degree of integrity. According to the PBS coordinator, Susan Velasquez, staff retraining is conducted if fidelity checks scores are below 90%. **Recommendations 5-6, June 2007:** • Ensure that all individuals who have severe maladaptive learned behaviors not amenable to change under unit behavioral guidelines

		are referred to the PBS teams for structural and functional analysis and interventions. • Ensure that WRPTs have a clear understanding of when they should refer cases to BCC and document their practice on the PBS-BCC checklist. **Findings:** The PBS teams work with unit staff to ensure that individuals in need of behavioral interventions are tracked and monitored and where indicated, behavioral interventions are developed and implemented. The Chief of Psychology and PBS team members review trigger data, and individuals who trigger are brought to the attention of the unit psychologist for review and consideration for services. PBS team members work with the unit psychologists in the development and implementation of behavioral interventions. PBS team members also attend WRPCs to review data on individuals' maladaptive behaviors. All referrals are handled through the PBS-BCC checklist. **Recommendation 7, June 2007:** Monitor the implementation of the PBS plans and ensure that the plans are used consistently across intervention settings. **Findings:** This monitor's review of PBS plans (HHD, JR, and ME) showed that team members conducted periodic fidelity checks to assess the integrity of implementation. Susan Velasquez, the PBS Coordinator, indicated that fidelity checks are conducted a week after the staff responsible for implementing the plan is trained, and periodically after that based on the data. According to the PBS coordinator, staff re-training is conducted if treatment integrity is below 90%. **Recommendations 8-9, June 2007:** • Collect objective information to evaluate the effectiveness of the

		PBS plans, including change in behaviors, stability of behavior change, changes in co-varying behaviors, achievement of broader goals and durability of behavior change. • Review the individual's progress on the PBS plan and make necessary changes, as indicted by the data and feedback from unit staff. **Findings:** This monitor's review of the PBS plans (HHD, ME, and JR) showed that PBS team members collect data on target behaviors during treatment implementation, graph and analyze data to revise the plans. **Recommendations 10-11, June 2007:** • Ensure that recommendations through the PBS plans take into consideration the conditions and limitations imposed by the unit environment. • Develop an appropriate tool to monitor this task. **Findings:** PBS plans implemented in the last six months (HHD, ME, and JR) complemented the unit rules and regulations. The interventions did not contain elements that acted as barriers to treatment implementation. According to the PBS coordinator, PBS staff consults with unit staff to ensure that elements in the treatment plan do not contravene unit regulations. PSH also uses the information gathered through the feedback section in the PBS plans to monitor the compatibility of the interventions with the unit rules and regulations. **Recommendation 12, June 2007:** Ensure that there is full administrative support for PBS teams. **Findings:** According to the Chief of Psychology, the PBS teams receive full support from the administration at PSH. This monitor's interview with

		staff and review of documents showed evidence of the administrative support to the PBS teams, which includes active recruitment to fill vacant positions, authorizing PBS psychologists to write orders on PBS plans, and supporting non-removal of PBS plans from charts except with signed forms from PBS team members. **Compliance:** Partial. **Current recommendations**: Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	**Compliance:** Partial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure that discipline-specific assessments include a section that states the implications of the assessment for rehabilitation activities. **Findings:** This monitor's review of discipline-specific templates showed that a section on "the implications of the assessment for rehabilitation activities" is included in the Integrated Rehabilitation Therapy Assessment, the Nursing Integrated Assessment, and the Social Work Integrated Assessment. This statement is not included in the Integrated Psychiatric Assessment Form. A good explanation about completing this statement is given in the Integrated Rehabilitation Therapy Assessment Instructions (page 6, section Viii). The Integrated Rehabilitation Therapy Assessment also includes good

information (section II, Functional Observations, pages 2-5) that can be used as elements of the individual's strengths, interests, and preferences for PSR therapy services, as well as for documentation of interventions in the individual's WRP.

Recommendation 2, June 2007:
WRPTs should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs.

Findings:
PSH used item#2 from the DMH Mall Alignment Monitoring Form to address this recommendation, reporting 15% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions.

	8/07	9/07	10/07	Mean
N	839	740	772	
n	14	20	32	
%C #2	21	20	9	15

PSH's audit of this cell needs to capture the individual's "assessed needs." The assessed needs are best captured from information in assessments including the behavioral assessments, PBS assessments, neuropsychological assessments, nursing assessments, psychiatric assessments, and Integrated Rehabilitation Therapy assessments. PSH should review these assessments and evaluate if the information from them are integrated into the individual's WRP. This monitor's review of ten charts (NL, JR, RM, MAM, GM, MD, CG, JG, SRT, RPJ) showed that

		six of them (NL, JR, RM, MAM, GM, and MD) contained information that did not get integrated into the individuals' WRPs or prioritized for further workup and services. **Recommendation 3, June 2007:** Expand the number of mall groups and individual therapies to accommodate the assessed needs and interests of individuals. **Findings:** PSH has increased the number of Mall groups offered by increasing Mall hours from 16 hours to 20 hours per week. PSH has also added new peer-facilitated Mall groups. PSH's commitment to meet EP guidelines is well presented in a memo, dated September 12, 2007, from its ED, Octavio Luna. However, PSH seems to have difficulties in meeting many of the Mall requirements due to staffing shortage in many disciplines and poor staff participation from a number of disciplines. The Clinical Administrator, Dr. Joseph Malancharuvil, has introduced a reorganization plan for the Mall (document dated November 14, 2007) to address this dilemma. The Clinical Administrator has formulated a Foci-based Mall structure. This monitor's review of documents showed that the Medical Executive Committee is in agreement with this plan. This monitor hopes that staff take heed of the ED's memo, and that the proposed "ideas" in the Mall restructuring working document to increase group size and/or reduce Mall hours as ways to handle facilitator shortage and to "balance" Mall group activities against individual/group therapies, becomes unnecessary; these changes in any event will be in non-compliance with EP. **Recommendation 4, June 2007:** Use systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to change the individuals' attitudes to

		participate in their assigned groups and individual therapies. **Findings:** PSH does not have a system for tracking and monitoring individuals who consistently fail to attend their assigned Mall groups. A few individuals that come to the staff's attention are served through the Recovery Enhancement Room and the Safe Clinic. PSH has very few staff trained in Narrative Restructuring Therapy and Cognitive Behavioral Intervention. According to Gari-Lyn Richardson, Director of Standards Compliance, training on these therapies was provided at the Annual Forensic Conference in September 2007, and PSH has plans to provide additional training through Drs. Judy Singh and Robert Wahler. **Current recommendations**: 1. WRPTs should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. 2. Expand the number of mall groups and individual therapies to accommodate the assessed needs and interests of individuals.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Current findings on previous recommendations:** **Recommendations 1-4, June 2007:** • Ensure that each individual has documented objectives. • Ensure that the learning outcomes are stated in measurable terms. • Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria. • Ensure that the courses offered have individualized objectives, observable outcomes, and evaluation measures for all individual attending the course. **Findings:** PSH used item #3 from the DMH Mall Alignment Monitoring Form to address this recommendation, reporting 28% compliance. The table

below with its monitoring indicator showing the number of WRP's due each month (N), the number of WRP's audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Has documented objectives, measurable outcomes and standardized methodology.

	8/07	9/07	10/07	Mean
N	839	740	772	
N	14	20	32	
%C #3	57	50	19	28

Findings:
This monitor observed a number of Mall groups (Smoking Cessation: You Can Quit and 64 Ways to Non-Violence). These groups did not have individualized objectives or measurable outcomes for all individuals in the groups. Many of the groups were large, making it difficult for the providers to give individualized attention. A number of facilitators/co-facilitators were not familiar with the individuals' objectives and discharge criteria as identified in their WRPs. The groups were not developed around the individuals' cognitive levels or at their stages of change. Facilitator monthly progress procedure has not been implemented.

This monitor reviewed 13 charts (OVM, AJP, RJ, HHD, JJJ, LGC, KJ, BLE, DE, MP, MH, RR, and DM). All of them had documented objectives. However, a number of them had objectives that were not a match with the foci. For example, RJ's focus 3.1 was on "Physically Assaultive", but one of the objectives was "Mr. J will wake up by 0730 am on weekdays 65% of the time for 2 consecutive months;" and HHD's focus 6.3 was "Poor Dentition", and the objective was "Mr. D will maintain weight within normal range."

		Current recommendations: 1. Ensure that the learning outcomes are stated in measurable terms. 2. Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria. 3. Ensure that the courses offered have individualized objectives, observable outcomes, and evaluation measures for all individuals attending the course.
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. **Findings:** This monitor reviewed 13 charts (OVM, AJP, FL, CK, JJJ, LGC, KJ, BLE, DE, MP, MH, RR, and DM). Five of the WRPs (FL, KJ, BLE, RR, and DM) had their objectives written in an observable/measurable manner, whereas the objectives in eight of them (OVM, AJP, CK, JJJ, LGC, DE, MP, and MH) were not written in an observable/measurable manner. **Recommendation 2, June 2007:** Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals. **Findings:** This monitor reviewed 16 charts (BLE, MS, AR, OM, EF, KA, JJJ, BMS, DM, FL, YT, JM, MP, RR, TA, and DE). There was alignment between the PSR scheduled activities and that identified in the individuals' WRPs, in five of them (MS, AR, OM, KA, and MP), but not for 11 of them (BLE, EF, JJJ, BMS, DM, FL, YT, JM, RR, TA, and DE).

Recommendation 3, June 2007:
When assigning individuals to mall groups, the WRPT members should be familiar with the contents of the group they recommend so that the groups they recommend are aligned with the individuals' needs.

Findings:
PSH used item #4 from the DMH Mall Alignment Monitoring Form to address this recommendation, reporting 12% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Is aligned with the individual's objectives that are identified in the individual's wellness and recovery plan.

	8/07	9/07	10/07	Mean
N	839	740	772	
n	14	20	32	
%C #4	21	16	6	12

This monitor's review of sixteen charts (BLE, MS, AR, OM, EF, KA, JJJ, BMS, DM, FL, YT, JM, MP, RR, TA, and DE) found that only five of the WRPs (MS, AR, OM, KA, and MP) aligned with the individuals' Mall groups/activities. This monitor's review of the Mall catalogues showed that the catalogues indexed the groups by title, stage of change, level of functioning, and with a brief description of the groups. According to the Mall Director, the catalogues are available as hard copies and as electronic versions to all WRPTs. This monitor's interview of WRPT members showed that they were aware of the availability of the catalogues. The poor alignment between the WRPs and the assignment to groups is more a function of the WRPTs not having all the data or not reviewing and integrating the available information from the

		discipline-specific assessments **Recommendation 4, June 2007:** Ensure that the individual's progress is tracked (using the PSH Mall Facilitator Monthly Progress Note) and that participation at different levels and in different groups is adjusted accordingly. **Findings:** PSH has yet to implement the Mall Facilitator Monthly Progress Notes procedure. According to the Mall Director, Melanie Byde, the Mall Progress Note procedure is to be implemented in December 2007. **Current recommendations**: 1. Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. 2. Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals. 3. Ensure that the individual's progress is tracked (using the PSH Mall Facilitator Monthly Progress Note) and that participation at different levels and in different groups is adjusted accordingly.
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. • Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services. **Findings:** PSH used item #5 from the DMH Mall Alignment Monitoring Form to

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<td>address this recommendation, reporting 6% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Utilizes the individual's strengths, preferences and interests.

<table>
<tr><td></td><td>8/07</td><td>9/07</td><td>10/07</td><td>Mean</td></tr>
<tr><td>N</td><td>839</td><td>740</td><td>772</td><td></td></tr>
<tr><td>n</td><td>14</td><td>20</td><td>32</td><td></td></tr>
<tr><td>%C #4</td><td>7</td><td>0</td><td>9</td><td>6</td></tr>
</table>

This monitor reviewed seven charts (LQ, JO, NB, MHK, RA, EJ, and KH). One of them (LQ) had consistently identified strengths in the interventions, whereas the remaining six did not (JO, NB, MHK, RA, EJ, and KH). A few facilitators seem to know the strengths of individuals attending their groups, especially individuals who were from their own WRPCs. In most cases, facilitators did not know the individual's strength/limitations. Nevertheless, large group size and poor group management strategies by facilitators were barriers to individualized attention.

Current recommendations:
1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual.
2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.</td>
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<td>C.2.i.v</td>
<td>focuses on the individual's vulnerabilities to mental illness, substance abuse, and</td>
<td>Current findings on previous recommendations:</td>
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readmission due to relapse, where appropriate;

Recommendation 1, June 2007:
Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members.

Findings:
PSH audited participation of WRPT members at the 7-day, 14-day, Quarterly, and Annual Conferences using Item #3 (*Each member of the team participates appropriately, competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitative services*), from the DMH WRP Observation Monitoring Form. The table below showing the disciplines, conference schedules, number of conference observed per schedule (n), and mean percentage of participation by each discipline at these conferences is a summary of the facility's data.

Disciplines	7-Day (n=152)	14-Day (n=264)	Qtrly (n=504)	Annual (n=74)
Psychiatrist	14	8	4	5
Psychologist	10	7	3	4
Social Worker	8	9	4	1
Rehab Therapist	5	4	1	1
Registered Nurse	5	5	1	0
Psychiatric Tech	3	2	1	0

As the table shows, clinical case formulation often is not conducted in an interdisciplinary fashion. The data in the table also show low participation of Social Workers in WRPCs. This indicates that discharge matters are not reviewed with the WRPT members and/or the individual at all WRPCs and that such information is not regularly updated in the Present Status section of the individual.

The four WRPCs observed by this monitor (BDM, DLG, AV, and JL)

		were interdisciplinary in nature with participation from almost all team members in each one. The interdisciplinary nature of the conferences might have occurred for three reasons: one, because of the monitor's presence; two because the PBS team members were participating in the WRPC, asking questions that brought about team discussions; and three, because the individuals in each of the conference failed to attend the conference and the team members used the time to discuss the cases. This monitor also reviewed sixteen charts (PAB, DM, MH, MS, AR, KA, EF, AJP, YT, JM, LC, KC, ALO, JR, ME, and HHD). Six of them (PAB, MS, EF, AJP, LC, and ALO) had documented evidence of having more than one discipline involved in the conference, including the individual, such was not the case in the other ten (DM, MH, AR, KA, YT, JM, KC, JR, ME, and HHD). **Recommendations 2-3, June 2007:** • Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. • Update the present status to reflect the current status of these vulnerabilities. **Findings:** PSH used item #6 from the DMH Mall Alignment Monitoring Form to address this recommendation, reporting 32% compliance. The table below with its monitoring indicator showing the number of WRPs due each month (N), the number of WRPs audited (N), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to mental illness, where appropriate.

	8/07	9/07	10/07	Mean
N	839	740	772	
n	14	20	32	
%C #4	50	63	9	32

This monitor reviewed 12 charts (HHD, JR, ME, RR, CK, KJ, MH, AR, DEM, IA, EF, and YT). Six of the WRPs (RR, CK, MH, IA, EF, and YT) in these charts addressed the individuals' vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors; with updates in the present status section of the individual's WRP. The remaining six (HHD, RJ, KJ, AR, DEM, and ME) did not properly document the individual's vulnerabilities in the predisposing, precipitating, and perpetuating factors, and/or update these vulnerabilities in the present status section of the individual's WRP.

Recommendations 4-5, June 2007:

- Develop and implement a training curriculum to ensure proper implementation by WRPTs of the staged model of substance abuse.
- Provide appropriate psychosocial rehabilitation services to individuals to preempt relapse.

Findings:

PSH has developed and implemented a training curriculum on the staged model of substance abuse. According to the Mall Director, Melanie Byde, the curriculum was completed in June 2007, and training of facilitators was conducted on July 20, 2007. This monitor reviewed the training curriculum. The curriculum includes sections on pre-test, introduction, explanations on the stages, instructions on sobriety and

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<td>recovery, and post-test.

PSH offers as many as 104 relapse prevention-focused groups. The table below shows the number of relapse prevention groups offered by Mall terms.

<table>
<tr><th>Winter 2007</th><th>Spring 2007</th><th>Summer 2007</th><th>Fall 2007</th></tr>
<tr><td>30</td><td>74</td><td>51</td><td>104</td></tr>
</table>

Current recommendations:
1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members.
2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.
3. Update the present status to reflect the current status of these vulnerabilities.</td>
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<tr>
<td>C.2.i.vi</td>
<td>is provided in a manner consistent with each individual's cognitive strengths and limitations;</td>
<td>Current findings on previous recommendations:

Recommendation 1-3, June 2007:
• PSR mall groups should address the assessed cognitive levels of the individuals participating in the group.
• Psychologists should assess all individuals suspected of having cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.
• Ensure that individuals with cognitive and neurocognitive challenges are evaluated by a DCAT team and assigned to mall groups that meet their cognitive strengths and limitations.

Findings:
PSH has a significant shortage in psychology staffing. PSH does not</td>
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		have a DCAT to conduct cognitive assessments. Psychologists review documentation of an individual's cognition as part of the Integrated Psychology Assessment during the first five days of an individual's admission. If necessary, the psychologists also conduct cognitive screening on individuals with schizophrenia spectrum disorders, history of substance abuse, and history of head trauma. Psychologists also conduct cognitive assessment of individuals 22 years and younger. **Current recommendations:** 1. PSR mall groups should address the assessed cognitive levels of the individuals participating in the group. 2. Ensure that individuals with cognitive and neurocognitive challenges are evaluated by a DCAT team and assigned to mall groups that meet their cognitive strengths and limitations.
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	**Current findings on previous recommendations:** **Recommendation 1-3, June 2007:** • Ensure that WRP teams receive timely progress notes on individuals' participation in their psychosocial rehabilitation services. • Automate this system. • Use the data from the PSR Mall Facilitator Monthly Progress Notes in the WRP review process. **Findings:** PSH has yet to implement the writing of Mall Facilitator Monthly Progress Notes. According to the Mall Director, this system will be in place in December 2007. **Current recommendations:** 1. Ensure that WRP teams receive timely progress notes on individuals' participation in their psychosocial rehabilitation

		services. 2. Automate this system. 3. Use the data from the PSR Mall Facilitator Monthly Progress Notes in the WRP review process.
C.2.i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Provide PSR mall groups as required by the EP. **Findings:** PSH has implemented the PSR Mall services as required by EP. According to the Mall Director, Since October 2007, Mall services are offered for 20 hours a week, an increase from the 16 hours of Mall services provided during the previous review. This monitor's review of the Mall schedules showed that Mall services are offered for four hours a day, two hours in the morning and two hours in the afternoon, for five days a week (Monday through Friday). **Recommendation 2, June 2007:** Mandate that all staff at PSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR mall during scheduled mall hours. This includes clinical, administrative and support staff. **Findings:** The ED has mandated that all individuals, including the clinical, administrative and support staff provide their scheduled hours of Mall services (Memorandum, September 12, 2007). Facilitators who are unable to provide the services on scheduled days and hours are required to seek approval. The table below shows the number of hours scheduled (N), the number

of hours of service provided by the staff (n) and the percentage of hours of service provided (%C) by the staff, reporting 77% compliance.

	May 07	June 07	July 07	Aug 07	Sep 07	Oct 07	Mean
N	1,001	890	1,077	1,135	736	1.071	
n	772	724	830	898	585	812	
% S	100	100	100	100	100	100	
% C	77.12	81.35	77.07	79.12	76.67	75.82	77.77

Recommendation 3, June 2007:
All mall sessions must be 50 minutes in length. Sessions less than that duration do not contribute to an individual's active treatment hours.

Findings:
The Mall Director has tracked and monitored the length of Mall group sessions. All Mall groups are scheduled for 50 minutes in length. The table below showing the number of groups held per month (N), the number of groups held for 50 minutes (n), and the percentage of groups meeting the time requirement (%C), reporting a mean percentage of 75% compliance, is a summary of the facility's data.

	May 07	June 07	July 07	Aug 07	Sep 07	Oct 07	Mean
N	5,793	4,013	5,588	5,916	5,916	7,469	
n	4,213	3,590	3,727	4,463	4,485	5670	
% S	100	100	100	100	100	100	
% C	72.00	89.45	66.00	75.4	75.81	75.91	75.37

Recommendation 4, June 2007:
Ensure that individuals participate in their scheduled hours.

Findings:
PSH audited the level of attendance by individuals for the last six months. The table below showing the number of hours scheduled per month (N), the number of hours of participation by individuals (n), and the percentage of participation (%C), reporting a mean of 72% compliance, is a summary of the facility's data.

	May 07	June 07	July 07	Aug 07	Sep 07	Oct 07	Mean
N	92,011	72,233	92,024	104,259	63,932	132,482	
n	68,414	57,720	60,044	71,882	48,732	96,502	
% S	100	100	100	100	100	100	
% C	74.35	79.91	65.25	68.95	76.22	72.84	72.41

Recommendation 5, June 2007:
Provide groups as needed by the individuals and written in the individuals' WRPs, adding new groups as needs are identified.

Findings:
PSH has implemented an add/drop form and a new group request form. WRP teams now can request new groups if one is needed. The Mall director stated that she has not received any request for new groups in the last six months. According to the Mall Director, the system will be linked electronically when the WaRMSS project is completed.

Current recommendations:
1. Mandate that all staff at PSH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR mall during scheduled mall hours. This includes clinical, administrative and support staff.
2. All mall sessions must be 50 minutes in length. Sessions less than that duration do not contribute to an individual's active treatment hours.

		3. Ensure that individuals participate in their scheduled hours. 4. Provide groups as needed by the individuals and written in the individuals' WRPs, adding new groups as needs are identified.
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	**Current findings on previous recommendation:** **Recommendation 1-2, June 2007:** • Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical, health, and physical limitations. • Ensure that therapy for individuals who are unable to ambulate or be transferred can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled mall activities. **Findings:** PSH has included individuals in bed-bound status within its Mall service structure. The Mall Director has taken upon herself to meet with bed-bound individuals discuss with them their service needs, after which she meets with the WRPT to address the needs of the individual. The Mall Director then identifies staff to provide services to the bed-bound individual. PSH did not have any individual in the bed-bound category during this review. **Current recommendations**: 1. Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical, health, and physical limitations. 2. Ensure that therapy for individuals who are unable to ambulate or be transferred can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled mall activities.

C.2.i.x	routinely takes place as scheduled;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. **Findings:** PSH offers Mall services for four hours a day, five days a week, Monday's through Friday's. Mall hours are regularly scheduled and implemented for two hours in the morning and two hours in the afternoon. In addition to staff-facilitated groups, PSH now has tapped into peer-facilitated groups. PSH is training as many as 24 individuals to be peer facilitators. PSH is proposing to restructure Mall groups by foci. PSH does not have a DCAT to conduct cognitive screening of individuals attending PSR Mall services. This monitor reviewed the Mall schedules of three individuals (HHD, ME, and JR). All three schedules were in alignment with the groups the individuals were attending and with the groups identified in their WRP's. However, review of ten WRPs (FL, MP, MH, OVM, KJ, DM, CC, RR, LCG, and JJJ) showed that WRP teams did not assign individuals to 20 hours of active treatment services. These individuals were assigned to as few as four hours (RR) and as high as 17 hours (FL) of treatment services. **Recommendation 2, June 2007:** Ensure that Mall groups and individual therapies are cancelled rarely, if ever. **Findings:** PSH audited the number of Mall groups scheduled per month and the number of groups held. The table below shows the number of groups scheduled per month (N), the number of groups cancelled (n), and the percentage of groups held (%C), reporting over 82% of groups held as

scheduled.

	May 07	June 07	July 07	Aug 07	Sep 07	Oct 07	Mean
N	92,011	72,233	92,024	104,259	63,932	132,482	
n	20,280	4,902	21,960	18,750	7,401	25,355	
% S	100	100	100	100	100	100	
% C	77.96	93.22	76.1	82.02	88.42	80.86	82.79

According to the Mall Director, cancellations of Mall groups were due to increase in Mall hours from 16 to 20 hours per week, staff vacancies in some departments, and poor staff participation from certain departments. The Mall Director expects cancellations to be minimal once the Focus Mall structure is implemented, and full staff participation is realized from all departments.

Recommendation 3, June 2007:
Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.

Findings:
This monitor's review of PSH's Mall facilitation hours by discipline showed that none of the disciplines provide the minimally required hours of service with the exception of the Administrator/Support staff. The table below shows the disciplines concerned, the expected number of service hours/week, and the percentage of service hours by disciplines in the Admission and the Non-admission Units.

	Required Hours/week	Admission Units	Non-Admission Units
Psychiatry	8	32.72%	15.81%
Psychology	10	31%	22.32%
Nursing	12	18%	7.74%

	Required Hours/week	Admission Units	Non-Admission Units
Social Work	10	61.56%	36.38%
Psychiatric Technicians	12	20.73%	10.09%
Rehabilitation Therapy	15	50.42%	23.96%

The Mall Director expects the ED memorandum and implementation of the Focus Malls to have a positive impact on staff participation during Mall hours.

Recommendation 4, June 2007:
Ensure that administrators and support staff facilitate a minimum of one Mall group per week.

Findings:
The Administrator/Support staff at PSH is required to provide a minimum of one hour of PSR Mall services per week. The table below shows the hours of service provided by the Administrator/Support staff, reporting 100% compliance.

	May 07	June 07	July 07	Aug 07	Sep 07	Oct 07	Mean
Avg weekly hours	2.44	2.66	2.56	2.46	1.86	3.28	
% S	100	100	100	100	100	100	
% C	100	100	100	100	100	100	100

As the data in the table show the Administrator/Support staff consistently outperforms the minimum requirement.

		Current recommendations: 1. Implement a more focused mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. 2. Ensure that mall groups and individual therapies are cancelled rarely, if ever. 3. Ensure that all disciplines facilitate a specified minimum number of hours of mall groups.
C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	**Current findings on previous recommendations:** **Recommendation 1-4, June 2007:** • Develop a list of all enrichment activities available along with names of staff competent in facilitating the activities in accordance with generally accepted professional standards of care. • Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. • Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. • Ensure that there is uniformity in the methodology and process of how the groups are organized and managed. **Findings:** Enrichment activities at PSH is organized and managed by each program/unit. This monitor's review of documentation on enrichment programs and activities showed that a variety of activities were offered in the evenings on weekdays and on the weekends. A sample of the activities conducted include AA/NA groups, exercises, cultural activities, church services, and a variety of field, table, and court

		games. There is no uniformity in how the groups are organized/ managed, except for the AA/NA group. The AA/NA group providers are trained by a coordinator, and the coordinator makes periodic visits to the groups to ensure that the groups are conducted properly. However, participation of individuals in enrichment activities is low. PSH may want to consider creating a staff position, who can report to the Mall Director, dedicated to tracking and monitoring the enrichment programs. **Current recommendations**: 1. Develop a list of all enrichment activities available along with names of staff competent in facilitating the activities in accordance with generally accepted professional standards of care. 2. Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. 3. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. 4. Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections. **Findings:** This monitor reviewed 13 charts (DM, TA, RR, YT, EF, DE, CK, JM, MA, LC, MH, HRB, and CC). Five of them (EF, DE, CK, MH, and LC) had the intervention milieu stated in the interventions, and the remaining eight

(DM, TA, RR, YT, JM, MA, HRB, and CC) did not have the intervention milieu stated in all the interventions.

Recommendation 2, June 2007:
Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.

Findings:
PSH used item #12 from the Therapeutic Milieu Observation Monitor to address this recommendation, reporting 25% compliance. The table below showing the number of audits attempted per month (N), the number of audits completed (n), and the percentage of compliance (%C) obtained is a summary of the facility's data.

	May 07	June 07	July 07	Aug 07	Sep 07	Oct 07	Mean
N	132	132	132	132	132	132	
n	118	126	100	122	42	109	
% S	89	95	76	92	32	83	
% C #12	32	26	26	21	48	12	25

This monitor's observation of Mall group activities (PSR Mall Groups Smoking Cessation: You Can Quit and 64 Ways to Non-Violence, Program 3, Unit 31) showed that facilitators reinforced individuals appropriately and often. However, the groups were large, as many as 50 individuals in some groups. The large group size sets up a situation in which individuals do not get to participate, especially with the poor organizational and managerial strategies used by the facilitator, and be reinforced.

Current recommendations:
1. All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections.

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<tr><td></td><td></td><td>2. Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.</td></tr>
<tr><td>C.2.j</td><td>Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.</td><td>Current findings on previous recommendations:

Recommendation 1-4, June 2007:
• Establish group exercises and recreational activities for all individuals.
• Provide training to mall facilitators to conduct the activities appropriately.
• Track and review participation of individuals in scheduled group exercise and recreational activities.
• Implement corrective action if participation is low.

Findings:
PSH offers the opportunity for all individuals to participate in a variety of group exercises and recreational activities. The table below shows the number of exercise groups offered by Mall terms.

<table><tr><td>Winter 2007</td><td>Spring 2007</td><td>Summer 2007</td><td>Fall 2007</td></tr><tr><td>77</td><td>102</td><td>82</td><td>109</td></tr></table>
According to the Mall Director, in December 2007 a coordinator will be responsible for the development of exercise and recreational activities, including training of facilitators. This monitor's review of the enrichment activity participation list showed that participation of individuals is low in most of the recreational and group exercises. PSH has not set up a system to track and monitor individuals' participation in their scheduled activities.

Compliance:
Partial.</td></tr>
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		Current recommendations: 1. Establish group exercises and recreational activities for all individuals. 2. Provide training to mall facilitators to conduct the activities appropriately. 3. Track and review participation of individuals in scheduled group exercise and recreational activities. 4. Implement corrective action if participation is low.
C.2.k	Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.	**Current findings on previous recommendations:** **Recommendation 1-4, June 2007:** • Conduct a needs assessment with individuals and/or their families. • Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. • Review pre-admission reports and services/treatments provided to identify the need for family therapy services. • Ensure that family therapy needs are fulfilled. **Findings:** This monitor's review of the Social Work 30-Day Psychosocial Assessment showed that a family needs assessment item is included in this assessment tool. According to the Chief of Social Work, this assessment tool received DMH approval in August 2007. PSH conducted staff training on this assessment tool in September 2007, and implemented the tool in October 2007. According to the Chief of Social Work, PSH also developed a survey instrument to identify individuals who may benefit from family therapy and/or family education. According to her, this survey was provided to social workers on November 6, 2007. The survey data is not available at this time.

		According to the Chief of Social Work, PSH is in the process of implementing an "Individual/Family Therapy Clinic." This clinic, when established, will be staffed by Social Workers and take referrals from WRPTs on family therapy needs. The Social Work service, in collaboration with the other state facilities, is developing a Family Education Group. Families can attend this group at a facility closest to them regardless of the state facility in which their family member is served. **Compliance:** Partial. **Current recommendations**: 1. The facility should develop a system for the provision of family education materials at admission and again during the process of discharge as indicated. 2. Ensure that family therapy services are provided as indicated.
C.2.l	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Develop and implement a system to ensure that all WRPs are reviewed during the year without duplication. **Findings:** PSH's progress report noted that samples for review are randomly selected. However, no other information was provided to ensure that there was no duplication and that all WRPs would be reviewed during the year. **Recommendation 2, June 2007:** Continue to monitor this requirement.

		Findings: The data from PSH's Medical Conditions Monitoring audit for May-October 2007, with sample sizes ranging from 7% to 19%, indicated that on average: • 26% of the opened medical conditions listed on the Medical Conditions List were identified in the WRP under Focus #6; • 7% of the general medical diagnoses were identified in the WRP; • 2% had the treatment to be employed identified in the WRP; • 4% of the related symptoms to be monitored by nursing staff were identified in the WRP; • 0% identified the means by which staff will monitor the symptoms; • 1% identified the frequency with which staff will monitor the symptoms; and • 6% identified by title the staff who were to perform these interventions. PSH indicated that the low compliance rates were related to the lack of training regarding Foci, Objectives, Interventions, and Mall Integration. From my review of 20 WRPs,(CK, RA, KS, JR, DJ, AC, RC, CM, TD, DA, DM, IM, JK, KMH, TEM, JGR, KJC, EYB, TT, OC,) I found that 14 did not have all opened medical conditions under Focus 6; 18 did not have the general medical diagnosis identified in the WRP; 18 did not have the treatment employed included in the WRP; 18 did not have the symptoms to be monitored identified in the WRP; none had the frequency of monitoring or the means to monitor listed in the WRP; and 17 did not identify the staff who were to perform the interventions listed in the WRP. These findings are similar to those of PSH. **Other findings:** A revised Medical Conditions Auditing tool has been completed by the

		Statewide Nursing Committee and is pending approval. **Compliance:** Partial. **Current recommendations:** 1. Provide training regarding the WRP process and required documentation. 2. Implement revised Medical Conditions Auditing tool when approved. 3. Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	The requirements of Section C.2.m are not applicable because PSH does not serve children and adolescents.
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Implement the policy and procedure regarding Substance Abuse Screening. **Findings:** PSH has yet to implement this recommendation. The facility's progress report does not address the recommendation.

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<td>Compliance:
Partial.

Current recommendations:
Implement the policy and procedure regarding Substance Abuse Screening.</td>
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<tr>
<td>C.2.o</td>
<td>Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.</td>
<td>Current findings on previous recommendations:

Recommendation 1, June 2007:
Continue monitoring using the Substance Abuse Checklist based on a 20% sample of a defined target population.

Findings:
PSH used the Substance Abuse Checklist to assess compliance with this requirement (May to October 2007). The average sample size was 11%. The sample was based on the number of WRPs with identified substance use problem that were audited each month (n) from the total target of the number of WRPs due each month (N). With the implementation of WaRMSS WRP system, the facility anticipates being able to revise its sampling method based on a more appropriate total target population (N=number of WRPs with identified substance use disorder). The following is an outline of the monitoring indicators and corresponding mean compliance rates:

<table>
<tr><td>1.</td><td>Substance abuse is identified in the 6 – Ps</td><td>56%</td></tr>
<tr><td>2.</td><td>There is an Objective and corresponding Intervention under focus #5–Substance Abuse</td><td>23%</td></tr>
<tr><td>3.</td><td>Individual's current Stage of Change is identified in the WRP</td><td>40%</td></tr>
<tr><td>4.</td><td>Identified Stage of Change is consistent with corresponding Objective(s) and Intervention(s) under focus # 5</td><td>8%</td></tr>
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5.	*Active activity (treatment) assignment matches with what is documented in the WaRMSS*	8%

PSH reported that the low compliance rates are related to insufficient training in WRP and substance use disorders. The facility's plan of correction was addressed in C.1.a.

PSH also used the DMH Chart Auditing process to assess compliance with the indicator regarding identification of substance abuse as a focus, with at least one corresponding objective and intervention. The following outlines the mean sample size and compliance rate for each type of WRP review:

WRP Review	Mean S%	Mean %C
7-day	10	27
14-day	14	17
Quarterly	22	17
Annual	13	7

Recommendation 2, June 2007:
Standardize the substance abuse auditing mechanisms across all State facilities based on the Substance Abuse Checklist.

Findings:
PSH has yet to implement this recommendation. The tool has been revised and submitted for statewide review.

Recommendation 3, June 2007:
The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program.

Findings:
PSH has yet to implement this recommendation.

		Recommendation 4, June 2007: Ensure that all individuals receive substance abuse services based on their assessed needs. **Findings:** PSH reported that this recommendation was partially implemented. However, the facility did not provide information in support of this report. **Other findings:** This monitor reviewed the charts of five individuals who were diagnosed with substance use disorders (BLC, RVB, SEB, QDB and SB). The review showed the following pattern: 1. Substance abuse was listed as a focus, with at least one corresponding objective/intervention in four charts (BLC, RVB, SEB, QDB, and SB); and 2. No chart included objectives/interventions that were appropriately linked to the stage of change. **Compliance:** Partial. **Current recommendations**: 1. Increase and strengthen training of WRPTs and SAS providers to improve assessment by the teams of the stages of change and the development of specific and individualized corresponding objectives and interventions. 2. Continue monitoring using the Substance Abuse Checklist based on a 20% sample of a defined target population. 3. Standardize the substance abuse auditing mechanisms across all state facilities based on the Substance Abuse Checklist.

		4. The substance recovery program should develop and utilize clinical outcomes for individuals and process outcomes for the program. 5. Ensure that all individuals receive substance abuse services based on their assessed needs.
C.2.p	Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.	**Current findings on previous recommendation:** **Recommendation 1-2, June 2007:** • Monitor the competency of group facilitators and therapists in providing rehabilitation services. • Ensure that providers have education, training and experience appropriate to the scope and complexity of services provided. **Findings:** PSH has not established a system to monitor the competency of group facilitators/therapists in providing rehabilitation services. However, according to Gari-Lyn Richardson, Director of Standards Compliance, PSH has entrusted an RN to train and monitor nursing facilitators. PSH has the same process in mind when senior staff positions are filled in Psychiatry, Psychology, Social Work, and Rehabilitation Therapy departments. **Compliance:** Partial. **Current recommendations:** 1. Monitor the competency of group facilitators and therapists in providing rehabilitation services. 2. Ensure that providers have education, training and experience appropriate to the scope and complexity of services provided.
C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field	**Current findings on previous recommendations:**

	of substance abuse should be certified substance abuse counselors.	**Recommendation 1-5, June 2007:** • Ensure that all group facilitators complete the substance abuse training curriculum. • Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. • Ensure that training includes all of the five stages of change. • Establish a review system to evaluate the quality of services provided by these trained facilitators. • Ensure that providers serving individuals at the pre-contemplation stage are trained to competency and meet substance abuse counseling competency. **Findings:** This monitor's review of PSH data showed that PSH has trained 99 of the 103 (96%) of its focus 5 substance abuse group facilitators. The majority of them also were certified in the pre-contemplative curriculum. The facilitators had to pass a post-test. According to Fred Wolfner, Program Director, Enhancement Services, the remaining four staff are off-duty and will receive the training when they return to duty. PSH has not completed the review system to evaluate the quality of services provided by the facilitators. **Compliance:** Partial. **Current recommendations:** 1. Ensure that all group facilitators complete the substance abuse training curriculum. 2. Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. 3. Ensure that training includes all of the five stages of change. 4. Establish a review system to evaluate the quality of services provided by these trained facilitators.

		5. Ensure that providers serving individuals at the pre-contemplation stage are trained to competency and meet substance abuse counseling competency.
C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	**Current findings on previous recommendations:** **Recommendation 1-2, June 2007:** • Establish an automated system to track cancellation of scheduled appointments. • Ensure that all appointments are completed. **Findings:** According to Gari-Lyn Richardson, the WaRMSS system is to be used to automate this requirement. The project is yet to be completed. This monitor's review of the PSH's self-evaluation data showed three cancellations out of the 195 scheduled appointments in September 2007. The three cancellations were due to transportation problems. There were 28 cancellations out of the 1715 internal appointments. These cancellations were reportedly due to staffing issues. PSH should collect and analyze data for all six months to get a better picture of the cancellation status. **Compliance:** Partial. **Current recommendations:** 1. Establish an automated system to track cancellation of scheduled appointments. 2. Ensure that all appointments are completed.
C.2.s	Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that	**Current findings on previous recommendations:**

	individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.	**Recommendation 1, June 2007:** Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments. **Findings:** PSH Mall groups are not organized into levels to address the cognitive levels of individuals within each course offered. Many of the groups are large, with individuals of varying cognitive levels, diagnoses, and mental illness and physical illness. This monitor's review of WRPs showed a number of limitations with group assignments. For example, HRB and YT did not have active treatments listed in their interventions; EJ, KH and RA did not have strengths listed in their interventions; NL's and NB's interventions were not aligned with their objectives; and JO had assaultive behavior and aggression noted in his WRP but there was no focus, objective, or intervention for this maladaptive behavior. **Recommendation 2, June 2007:** Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs. **Findings:** PSH has not established a system to track and monitor facilitator competency. PSH has designated a registered nurse to train nursing facilitators. PSH is planning to do the same when senior staff is hired in all other disciplines. This monitor's observation of Mall groups showed that most facilitators possess the necessary fund of information to facilitate the course; however, they appear to be deficient in organizational and managerial skills. Besides, a number of groups are large (as many as 50 individuals in number), making the facilitator's task even more difficult. Co-facilitators in many of the groups did not "co-facilitate."

		Recommendation 3, June 2007: Ensure that progress notes are written in a timely fashion and made available to the individual's WRPT. **Findings:** PSH has yet to implement this recommendation. **Recommendation 4, June 2007:** Develop and implement monitoring systems that address all of the required elements. **Findings:** PSH has decided to use item #10 from the DMH Clinical Chart Auditing Form (*Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care*) to address this recommendation. PSH audited 533 Quarterly and Annual WRPs, reporting 0% compliance. The monitor's review of WRPs, as discussed under Recommendation 1, is in agreement with the facility's findings. **Compliance:** Partial. **Current recommendations**: 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments. 2. Ensure that providers and facilitators are knowledgeable,

		competent, and motivated to translate course content to meet individuals' needs. 3. Ensure that progress notes are written in a timely fashion and made available to the individual's WRPT.
C.2.t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;	**Current findings on previous recommendations:** **Recommendation 1-2, June 2007:** • Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. • Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP. **Findings:** PSH used item #11 (*Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof*) from the DMH Clinical Chart Auditing Form, to address this recommendation, reporting 0% compliance. This monitor's observation of Mall groups, WRPCs, and review of WRPs (HRB, YT, EJ, KH, HHD, JR, ME, RA, NL, NB, and JO) showed significant problems with compliance to these recommendations. Some WRPs do not have a match between the focus and the objectives, and the objectives with the interventions; the interventions did not include all the elements required in the interventions; and many of them did not have active treatment groups listed in the interventions. The WRP teams do not regularly revise objectives and interventions based on the individual's progress or lack thereof in their treatments/therapies. When revision/changes are not made, there is no documentation of clinically justifiable reasons for continuing with the same

		objectives/interventions. WRPTs, on the other hand, do not receive data from facilitators on the individual's progress that the WRPTs could then use to revise the WRPs. **Recommendation 3-4, June 2007:** • Implement and monitor PSH Mall Facilitator Monthly Progress Notes. • Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual. **Findings:** PSH has yet to implement the Mall Progress Note procedure. **Compliance:** Partial. **Current recommendations**: 1. Implement and monitor PSH Mall Facilitator Monthly Progress Notes. 2. Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual.
C.2.u	Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Increase the number of groups that offer education regarding the purposes of WRP services. **Findings:** PSH has data showing that the number of groups has decreased since January 2007. The following table is an illustration:

# of WRP Groups Offered by Mall Term			
Winter	Spring	Summer	Fall
42	60	20	26

Recommendation 2, June 2007:
Develop and implement a monitoring tool to address this requirement, including groups offered and provided and individuals' attendance and participation.

Findings:
MAPP data are currently the source of monitoring information. The facility presented data regarding the New Admission Orientation (NAO) groups that offer WRP education. The data show compliance rates of 79%, 47% and 22% during the months of August, September and October 2007, respectively. The compliance rates are based on the number of individuals attending the WRP education section of the NAO groups.

Recommendation 3, June 2007:
Develop a tracking mechanism to ensure that individuals are provided a copy of their WRP based on clinical judgment.

Findings:
The WaRMSS WRP module provides a checkbox when staff provides the WRP to the individual and a place to document why it was not given when clinically appropriate. PSH will begin monitoring for this requirement in December.

Compliance:
Partial.

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<td>Current recommendations:
1. Increase the number of groups that offer WRP education, and provide data analysis and corrective actions to improve compliance.
2. Provide data regarding number of individuals attending WRP education and data analysis and corrective actions to improve compliance.
3. Monitor implementation of the requirement to provide individuals a copy of their WRPs, when clinically appropriate.</td>
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<tr>
<td>C.2.v</td>
<td>Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.</td>
<td>Current findings on previous recommendations:

Recommendation 1, June 2007:
Increase the number of groups that offer education regarding medication management.

Findings:
PSH has made some progress regarding this recommendation. The following table summarizes the facility's data.

<table>
<tr><td colspan="4"># of Medication Education Groups Offered by Mall Term</td></tr>
<tr><td>Winter 2007</td><td>Spring 2007</td><td>Summer 2007</td><td>Fall 2007</td></tr>
<tr><td>31</td><td>46</td><td>34</td><td>48</td></tr>
</table>

Recommendation 2, June 2007:
Develop and implement a monitoring tool to address this requirement, including groups offered and provided and individuals' attendance and participation.

Findings:
At present, PSH monitors the number of groups offered but not the individuals' attendance and participation. The facility has a plan to</td>
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		utilize Mall progress notes (when implemented) and the MAPP program to implement this recommendation during the next review period. **Compliance:** Partial. **Current recommendations**: Increase the number of groups that offer education regarding medication management.
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Same as C.2.f.vi. **Findings:** Same as C.2.f.vi. **Recommendation 2, June 2007:** Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation. **Findings:** PSH has yet to implement this recommendation. The facility expects to report accurately on the individuals' non-adherence to the WRP when the MAPP system is implemented into WaRMSS (within approximately two months). At that time, PSH expects to explore barriers to adherence and to provide strategies to resolve these barriers. **Recommendation 3, June 2007:** Provide training to the WRPTs to ensure implementation of: a) Appropriate individual therapy to individuals' non-adherence to WRP; and

		b) Clinical strategies to help individuals achieve readiness to engage in group activities. **Findings:** PSH has yet to implement this recommendation. The facility reports that a statewide contract for Motivational Interviewing is being established. **Recommendation 4, June 2007:** Develop and implement monitoring tools to assess compliance with this item. **Findings:** PSH has yet to implement this recommendation. The current AD (#14.45, Key Indicator/Trigger Reporting) codifies adequate mechanisms for notification of the WRPTs when an individual has triggered for non-adherence to the WRP and for the teams to then initiate a Trigger Action Sheet describing the actions taken to address this issue. These mechanisms have yet to be implemented. **Compliance:** Partial. **Current recommendations**: 1. Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation. 2. Use systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to change the individuals' attitudes to participate in their assigned groups and individual therapies. 3. Provide training to the WRPTs to ensure implementation of: a) Appropriate individual therapy to individuals' non-adherence to WRP; and

		b) Clinical strategies to help individuals achieve readiness to engage in group activities. 4. Develop and implement monitoring tools to assess compliance with this item.

D. Integrated Assessments		
D	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.	**Summary of Progress on Psychiatric Assessments and Diagnoses:** PSH has improved its auditing methodology and data presentation regarding psychiatric assessments and reassessments. **Summary of Progress on Psychological Assessments:** 1. DMH Psychology Manual is Completed and in use. 2. Psychology monitoring forms have been standardized. 3. Integrated Psychological Assessments have been standardized. 4. The Psychology Department has published Newsletters with a section dedicated to feedback on EP. 5. There is a significant improvement in the timeliness of the academic/cognitive assessments. 6. The new template and format is used when conducting Psychology Focused Assessments. 7. There has been progress in most recommendations (improvement in nearly 75% of the recommendations) in comparison with the previous review. 8. PSH has taken steps to address assessment of individuals admitted before the effective date by arranging staff to work an additional 10 hours/week, to catch up with the backlog. 9. There is a significant increase in the number of behavioral guidelines implemented. **Summary of Progress on Nursing Assessments:** 1. PSH has begun implementation of the new statewide Nursing Admission Assessment and Integrated Assessment. 2. PSH has initiated a mentoring/monitoring system for review of Nursing Admission Assessments. 3. Nursing has added a number of new training courses to New Employee Orientation and to the annual training rosters.

		Summary of Progress on Rehabilitation Therapy Assessments: IA-RTS pilot was completed with positive feedback from staff and individuals reported, as well as an improvement in assessment quality upon record review. **Summary of Progress on Nutrition Assessments:** Despite progress regarding quality of system and assessments, Nutrition Services is in jeopardy of not reaching substantial compliance secondary to staffing shortages. **Summary of Progress on Social History Assessments:** 1. PSH has finalized and implemented the Psychosocial Assessment Forms. 2. The Social Work Service has reorganized its staff, assigning Supervising Social Work staff to each EP monitoring section (Admission, Assessment, Discharge Planning, Family Therapy). 3. The Social Work Service has established an assessment team to support unit social work staff with the 30-day Social Work Assessments. 4. The Social Work manual now is on the PSH Intranet system, making it readily available for reference. 5. PSH has implemented the Family Therapy Assessment Survey. **Summary of Progress on Court Assessments:** PSH has made sufficient progress to achieve substantial compliance with EP requirements regarding PC 1026 and PC 1370 Court Reports.

1. Psychiatric Assessments and Diagnoses		
	Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,	**Methodology:** Interviewed: 1. Sarla Gnanamuthu, MD, Medical Director 2. Wadsworth Murad, MD, Acting Chief of Psychiatry 3. Stephen Mauer, MD, Chief of Medical Staff 4. Gari-Lyn Richardson, Standards Compliance Director 5. Paul Guest, PhD, Standards Compliance Department Reviewed: 1. The charts of 42 individuals: AMG, AYH, BHF, CH-2, CRM, DAA, DC, EA, GLC, GWD, HS, IM, JC, JJC, JMG, JML, JP, JR, KC, LAR, LC, LEM, LER, LJS, LLC, MAF, OA, OC, RLW, RRP, RTD, SB, SEB, SF, SKG, TAB, TLB, TN, WJB, VEB, WEK and WP 2. PSH Admission Psychiatric Assessment Auditing Form 3. Admission Psychiatric Assessment summary data (June to October 2007) 4. PSH Integrated Psychiatric Assessment Auditing Form 5. Integrated Psychiatric Assessment Auditing summary data (May to June and August to September 2007) 6. PSH Admission Medical Assessment Auditing Form 7. Admission Medical Assessment Auditing summary data (May to October 2007) 8. PSH Physician Progress Note Auditing Form 9. Physician Progress Note Auditing summary data (May to September 2007) 10. PSH Medication Monitoring PRN Auditing Form 11. Medication Monitoring PRN Auditing summary data (August 2007) 12. PSH Medication Monitoring Stat Auditing Form 13. Medication Monitoring Stat Auditing summary data (September 2007) 14. PSH Physician Transfer Note Auditing Form

		15. Physician Transfer Note Auditing summary data (May to October 2007) <u>Observed</u>: 1. WRPC (Program VI, unit EB-01) for 14-Day review of SKG 2. WRPC (Program VI, unit EB-01) for monthly review of SDR 3. WRPC (Program IV, unit 36) for quarterly review of KH 4. WRPC (Program I, unit EB-11) for quarterly review of JL
D.1.a	Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.	**Current findings on previous recommendations:** **Recommendation 1-3 and 5 June 2007:** • Continue to monitor this requirement using the Initial Admission Assessment, Psychiatric Evaluation, Monthly Progress Note and Clinical Chart Auditing Forms. • Do not use convenience samples and ensure random sample sizes of 20% of the total target populations. • Include monitoring data regarding assessment of diagnosis and medications given at previous facilities. • Address and correct factors related to low compliance. **Findings:** The facility used the PSH Initial Admission Psychiatric Assessment, Integrated Psychiatric Assessment and Physician Progress Notes Auditing Forms to assess compliance. In these processes, the facility adequately addressed the deficiencies in auditing methodology that were outlined by this monitor in the previous report. However, the overall mean reliability has yet to be determined. PSH reported that resources to conduct auditing have improved over the past several months, but there continues to be difficulty in obtaining and maintaining sufficient resources to provide required sample sizes in all months of monitoring. Reportedly, the Department

		of Psychiatry members have been educated and informed of this data and the facility has a plan to ensure that Senior Psychiatrists will review the cases that involve low compliance with the individual psychiatrists on the units. The following is a summary of the facility's data, including the auditing form used, months of monitoring, with average sample size (S) and monitoring indicators, with corresponding mean compliance rates: **PSH Admission Psychiatric Assessment Auditing Form (June to October 2007, S=32% of admissions per month):** 1. *Admission diagnosis Axis I-V is documented* 94% 2. *DSM diagnosis is consistent with history and presentation* 91% 3. *No Diagnosis is clinically justified and documented, when applicable* 25% 4. *Discharge diagnosis included from sending facility* 51% PSH recognized that the above data showed a decrease in compliance in June and July. Reportedly, this was a result of few cases being audited during that time period and more of those cases were assessments completed by one physician who was identified as needing additional training and mentoring. The training and mentoring has reportedly occurred and the assessments and trends have improved and stabilized. **PSH Integrated Psychiatric Assessment Auditing Form (May to June and August to September 2007,S=20% of the number of integrated assessments due per month):** 1. *Statements from the individual are included* 80% 2. *Diagnosis and medications given at previous facility are included* 72%

		3. *Diagnostic formulation is documented* 72% 4. *Documentation addresses findings which may support other diagnosis, including No Diagnosis* 63% 5. *Documentation includes pertinent positive and negative findings related to differential diagnosis* 54% 6. *DSM IV-TR addresses 5 axes* 86% 7. *Includes the diagnostic criteria for the given diagnosis* 69% **PSH Physician Progress Note Auditing Form (May to September 2007,S=6% of the number of the individuals in the hospital for more than seven days):** 1. *The current diagnosis is listed with evidence to support any diagnosis changes as appropriate* 65% 2. *The justification of diagnosis is in accord with the criteria contained in the most current DSM-IV-TR* 62% 3. *There is a current DSM-IV TR checklist* 32% 4. *Any differential diagnosis including deferred include a rationale and are resolved within 60 days* 4% 5. *Any differential diagnosis including rule out include a rationale and are resolved within 60 days* 3% 6. *Any diagnosis listed as NOS include a rationale and are resolved within 60 days* 2% 7. *No Diagnosis is clinically justified and documented* 1% PSH reported that low compliance in the above data appeared to be related to the lack of standardized format being used for the physician's progress note. Additionally, the weekly progress notes conducted within the first 60 days of admission were being audited to the same standard as monthly progress notes for individuals hospitalized longer than 60 days. The facility plans to use a format for psychiatric progress notes following standardization of the psychiatric monitoring tools at the state level.

		Recommendations 4 and 6, June 2007: • Finalize statewide efforts to consolidate and standardize monitoring indicators in current forms that assess psychiatric assessments. • Standardize the names of the monitoring instruments statewide and ensure that the facilities' progress reports use these names consistently. **Findings:** This has yet to be implemented. A statewide meeting is scheduled to be held at MSH (December 10-14, 2007) to accomplish this task. **Other findings:** Chart reviews by this monitor indicate that the psychiatric diagnoses are, in general, stated in terminology that is consistent with the current version of DSM. However, there continue to be deficiencies in the admission and integrated psychiatric assessments (see D.1.c.ii and D.1.c.iii) in the overall quality of information needed for adequate diagnostic accuracy. These deficiencies must be corrected to achieve substantial compliance with this requirement. **Compliance:** Partial. **Current recommendations:** 1. Finalize statewide efforts to consolidate and standardize monitoring instruments regarding psychiatric initial and integrated assessments (initial, integrated and transfer) and reassessments. 2. Continue to monitor this requirement using the Initial Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms and ensure sample size of at least 20%.

		3. Provide data analysis regarding areas of low compliance, with corrective actions. 4. Provide ongoing feedback and mentoring by senior psychiatrists to correct the deficiencies outlined by this monitor (D.1.c.i through D.1.c.iii).
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	**Current findings on previous recommendation:** **Recommendation, June 2007:** Ensure that all psychiatry staff is in compliance with the requirement. **Findings:** As of October 31, 2007, 77 psychiatrists are employed at the facility. All of these psychiatrists, with the exception of three, are in compliance with the requirement. As mentioned in the previous report, these three psychiatrists have been grandfathered under the State of California's civil employment rules and are working under the direct supervision of the Acting Chief of Psychiatry. The facility's Medical Staff Bylaws require that all newly hired psychiatrists meet this requirement. At present, the number of psychiatrists who have achieved board certification in psychiatry is 35. **Compliance:** Partial. **Current recommendations:** Ensure that all psychiatrists who function as attending physicians and are responsible for performing or reviewing psychiatric assessments are in compliance with this requirement.

D.1.b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Implement the Physician Performance Profile and utilize data in the process of reappointment/reprivileging. **Findings:** PSH has yet to implement this recommendation. The facility's template is scheduled to be implemented in January 2008. **Compliance:** Partial. **Current recommendations:** Implement the Physician Performance Profile and utilize data in the process of reappointment/reprivileging.
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Continue to monitor this requirement, and include refusals and deferrals of the examination and follow up as well as completeness and quality of the examination. • Identify barriers to compliance with the requirement regarding completeness of the physical examination and develop and implement corrective actions. **Findings:** PSH monitors this requirement for completeness only and plans are

		underway to implement monitoring for quality, refusals and deferrals of the examination. Using the PSH Initial Admission Medical Assessment Monitoring Form, the facility reviewed an average sample of 87% of admissions per month (May to October 2007). The mean compliance rate was 97% regarding completion of the medical assessment within 24 hours of admission. The mean compliance rates for the requirements in D.1.c.i.1 through D.1.c.i.5 are presented for each corresponding sub-cell below. This monitoring was conducted by the Standards monitor. **Other findings:** This monitor reviewed the charts of 12 individuals (AYH, JML, TAB, CRM, AMG, SB, CH-2, SKG, SF, EA, WJB and SEB). The review corroborated the facility's data regarding completeness of the history and examination. Persistent deficiencies were found in the completion of genital and rectal examination of male individuals (JML, CRM, and SKG) and documentation of follow-up regarding the individual's refusal of the physical examination (EA) or parts of the examination (CH-2 and WJB). The facility maintained adequate practice in the completion of gynecological and rectal examinations of female individuals at the OB-GYN clinic at reasonable intervals following admission (e.g. TAB). **Compliance:** Partial. **Current recommendations:** 1. Continue to monitor this requirement, and include refusals and deferrals of the examination and follow-up as well as completeness and quality of the examination. 2. Identify barriers to compliance with the requirement regarding completeness, quality and follow-up of refusals of the physical examination and develop and implement corrective actions.

D.1.c.i.1	a review of systems;	97%
D.1.c.i.2	medical history;	97%
D.1.c.i.3	physical examination;	89%
D.1.c.i.4	diagnostic impressions; and	97%
D.1.c.i.5	management of acute medical conditions	95%
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Ensure that the mental status examinations are completed on all admission • Monitor the admission psychiatric examination for timeliness, completeness and quality and ensure that the overall compliance rate accounts for the completeness and quality of each item. **Findings:** PSH used the PSH Initial Admission Psychiatric Assessment Auditing Form to monitor this requirement. The facility reviewed an average sample of 32% of admissions per month (June to October 2007). The mean compliance rate was 99% regarding completion of the psychiatric assessment within 24 hours of admission. The mean compliance rates for the requirements in D.1.c.ii.1 through D.1.c.ii.6 are presented for each corresponding sub-cell below. **Other findings:** Reviewing the charts of the above-mentioned 12 individuals, this monitor found that compliance was much lower than that reported by the facility. The review showed that virtually no progress was made in addressing the deficiencies that were reported by this monitor in the

		previous report. It is noteworthy that most of the deficient assessments were completed by the same provider. The following is an outline of the significant current deficiencies: 1. The admission assessment was missing in the charts of CRM and WJB. 2. The presenting psychiatric history was inadequate in the charts of AYH, AMG, SB, TAB and SEB. 3. The pertinent past psychiatric history was inadequate in the chart of AMG. 4. There was no narrative to describe high risk factors and/or positive history/mental status examination findings, with examples as follows: a. Aggression (SB, EA, SF and SEB); b. Suicide and self-abuse/injury (EA); c. Mood and affect: EA and SB; d. Auditory hallucinations (AMG, TAB, SF and SEB); e. Persecutory delusions (SEB, SF, TAB and AMG); 5. The plan of care was missing in the charts of TAB, AMG, SB, EA and SEB. 6. The plan of care was inadequate in the chart of SF 7. The assessment did not include a diagnosis in the chart of EA. 8. Some assessments (TAB, SB and SEB) were completed in a careless manner and were seriously sub-standard in overall quality. **Compliance:** Partial. **Current recommendations**: 1. Monitor the admission psychiatric assessment for timeliness, completeness and quality and ensure that the compliance rates account for the completeness and quality of each item. 2. Identify barriers to compliance and develop and implement

		corrective actions.
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	38%
D.1.c.ii.2	complete mental status examination;	73%
D.1.c.ii.3	admission diagnoses;	Same as in D.1.a.
D.1.c.ii.4	completed AIMS;	98%
D.1.c.ii.5	laboratory tests ordered; and	93%
D.1.c.ii.6	consultations ordered.	93%
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Ensure that the assessment integrates information that cannot be obtained at the time of admission but becomes available during the first seven days of admission. • Ensure that monitoring of compliance addresses the quality of documentation, not just its presence or absence. **Findings:** PSH used the PSH Integrated Psychiatric Assessment Auditing Form to assess compliance. The facility reviewed an average sample of 20% of integrated assessments due per month (May to June and August to September 2007). The mean compliance rate regarding timeliness of the assessment was 81%. The mean compliance rates for the requirements in D.1.c.iii.1 through D.1.c.iii.10 are presented for each corresponding sub-cell below.

		Recommendation 3, June 2007: Develop and implement strategies to address and correct the deficiencies outlined above. **Findings:** PSH conducted some data analysis in an effort to identify and correct barriers to compliance with different requirements of the integrated assessment. The following is a summary of the current factors that impact compliance: 1. Psychiatric history: lack of data regarding effectiveness of medications given at previous facilities requires attention in the interpretation of data. 2. Psychosocial history: frequent changes in assignments of social work staffing should be resolved. 3. Mental status examination: lack of MMSE in some assessments should be addressed by Senior Psychiatrists. In addition, breakdown of Plato data is needed to objectively assess overall compliance. 4. Strengths: feedback is needed by Senior Psychiatrists. 5. Psychiatric risk factors: training is needed regarding required components of risk assessments. 6. Diagnostic formulation and differential diagnosis: training of auditors and feedback to practitioners are needed by Senior Psychiatrists. 7. Current psychiatric diagnosis: lack of completion of DSM-IV checklists by non-psychiatrists needs to be resolved. **Other findings:** This monitor reviewed the above-mentioned 12 charts. Overall, some progress was made in addressing the deficiencies outlined by this monitor in the previous report. However, there continue to be deficiencies that must be corrected to achieve substantial compliance.

		The following are examples of current deficiencies: 1. The assessment was missing in the chart of AMG. 2. Psychosocial history was missing in the charts of some individuals (CH-2 and JML), with no subsequent documentation in the WRPs of this history (including those cases when the individual had initially refused to provide information). 3. The risk assessment did not specify most recent dangerous acts (suicide/violence/fire setting), severity of these acts and mitigating factors (SB and EA). 4. There was inadequate assessment of current suicidal ideations in the chart of SEB. 5. There was misunderstanding by some practitioners of the difference between diagnostic formulation required as part of the integrated assessment and the WRP's interdisciplinary case formulation (EA and SKG). 6. There was no differential diagnosis to address diagnoses listed as R/O and/or NOS in the charts of SKG, SB and CH-2. 7. Some assessments included inappropriate formulation of strengths that cited characteristics such as physical health, adequate judgment and/or intelligence rather than attributes that can impact planning of services (CH-2, AYH and WJB). 8. The impairments in insight and judgment were often described in generic terms (SF, SKG, SM and SEB). 9. There was no signature by the psychiatrist who performed the assessment in the charts of SKG and CRM. **Compliance:** Partial. **Current recommendations**: 1. Monitor the integrated psychiatric assessment for timeliness, completeness and quality and ensure that the compliance rates

		account for the completeness and quality of each item. 2. Identify barriers to compliance and develop and implement corrective actions.
D.1.c.iii.1	psychiatric history, including a review of present and past history;	44%
D.1.c.iii.2	psychosocial history;	80%
D.1.c.iii.3	mental status examination;	68%
D.1.c.iii.4	strengths;	76%
D.1.c.iii.5	psychiatric risk factors;	36%
D.1.c.iii.6	diagnostic formulation;	72%
D.1.c.iii.7	differential diagnosis;	57%
D.1.c.iii.8	current psychiatric diagnoses;	15%
D.1.c.iii.9	psychopharmacology treatment plan; and	63%
D.1.c.iii.10	management of identified risks.	87%
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Provide continuing medical education to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders.

Findings:
During this review period, PSH has facilitated several educational events to address this recommendation. The following is an outline of the relevant programs, with dates and names of instructors/providers. PSH did not provide data regarding number and disciplines of those who attended these events.

Program	Date(s)	Instructor/Provider
Symptom Recognition and Differential Diagnosis of Brain Encephalopathy and Dementias	8/15/07	William Britt, PhD, Neuropsychologist, PSH, Loma Linda University, Dominique Kinney, PhD, Neuropsychologist, PSH, and Steve Nitch, PhD, Neuropsychologist, PSH
Abnormal Involuntary Movement Scale: Practical Use for Five Levels of Symptomatology	5/9/07 and 5/16/07	Jay M. Pomerantz, MD, Assistant Clinical Professor of Psychiatry, Harvard School of Medicine
Cognitive Deficits in Schizophrenia: Assessment and Treatment	11/14/07	Videoconference, University of Cincinnati

Recommendation 2, June 2007:
Same as in D.1.a.

Findings:
Same as in D.1.a.

Other findings:
This monitor reviewed the charts of 17 individuals who have received diagnoses listed as NOS continuously for more than three months during the past year. The review showed a general pattern of inadequate documentation, evaluation and/or updates of these disorders. The following is an outline of these reviews:

Initials	Diagnosis
LLC	Mental Disorder, NOS
RTD	Medication-Induced Movement Disorder, NOS
JP	Amphetamine-Related Disorder, NOS (and Amphetamine Dependence)
VEB	Psychotic Disorder, NOS (till 11/14/07) and Anxiety Disorder, NOS
TLB	Psychotic Disorder, NOS
LEM	Psychotic Disorder, NOS
JG	Psychotic Disorder, NOS and Cognitive Disorder, NOS
GLC	Psychotic Disorder, NOS and Anxiety Disorder, NOS
IM	Dementia, NOS, with Delusions
LAR	Impulse Control Disorder, NOS
GWD	Impulse Control Disorder, NOS
HS	Cognitive Disorder, NOS
JJC	Cognitive Disorder, NOS (with Executive Dysfunction)
LJS	Cognitive Disorder, NOS (Mild Neurocognitive Disorder)
JMG	Depression, NOS
WEK	Depressive Disorder, NOS (and Schizoaffective Disorder)
RRP	Depression, NOS

		Compliance: Partial. **Current recommendations**: 1. Continue medical education programs to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders and provide data regarding number and disciplines of attendees. 2. Same as in D.1.a.
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as in D.1.d.i. **Findings:** Same as in D.1.d.i. **Compliance:** Partial. **Current recommendations**: Same as in D.1.d.i.
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as D.1.d.i. **Findings:** Same as D.1.d.i.

		Compliance: Partial. **Current recommendations**: Same as D.1.d.i.
D.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as in D.1.d.i. **Findings:** Partial. **Other findings:** According to the Acting Chief of Psychiatry, there were five individuals who received "No Diagnosis" on Axis I during this review period. No information was provided regarding the facility's monitoring of these cases to determine clinical justification. Chart reviews by this monitor did not show any cases of Axis I diagnosis listed as "no diagnosis." **Compliance:** Partial. **Current recommendations**: 1. Same as in D.1.d.i. 2. Audit all individuals who have received "No Diagnosis" on axis I to determine clinical justification.
D.1.e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that	**Current findings on previous recommendation:**

	reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	**Recommendation 1, June 2007:** Assess and correct factors related to low compliance with the requirement when LOS is less than 60 days. **Findings:** PSH used the PSH Physician Progress Note Auditing Form to assess compliance. The average sample size was 12% of the number of individuals who have been hospitalized for less than 60 days (May to September 2007). The mean compliance rate was 51%. The facility identified the following barriers to compliance (on the admission units): 1. High admission rate; 2. Strained staffing resources; 3. Increased work load on developing WRPCs; and 4. Learning curve involved in completing the initial conversion to the WaRMSS version of the WRP. PSH plans to open another admission unit as soon as staffing resources become available and anticipates that continued implementation of the WaRMSS version of the WRP will facilitate compliance. **Recommendation 2, June 2007:** Monitor the frequency of documentation when LOS is more than 60 days. **Findings:** Using the above-mentioned auditing process, PSH reviewed an average sample of 6% of the number of individuals who have been hospitalized for more than 60 days (May to September 2007). The facility reported a mean compliance rate of 77%. **Other findings:** This monitor reviewed the charts of six individuals (TAB, CRM, SB, CH-

		2, SKG and SEB) to assess the frequency of psychiatric notes during the first 60 days of admission. The review showed compliance in five charts and partial compliance in one (SKG). **Compliance:** Partial. **Current recommendations**: Monitor this requirement based on at least a 20% sample and analyze and correct factors related to low compliance.
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Standardize the format for psychiatric reassessments statewide. **Findings:** This recommendation has yet to be implemented. Statewide efforts are underway. **Recommendation 2, June 2007:** Ensure that requirements regarding the integration of pharmacologic and behavioral treatments are clearly incorporated in the current monitoring indicators and/or instructions. **Findings:** The current PSH Physician Progress Note Auditing Form has two items (#15 and #16) that adequately address this recommendation. **Recommendation 3, June 2007:** Address and correct factors related to low compliance with this requirement.

Findings:
PSH assessed that low compliance with the requirements under D.1.f is related to the lack of a standardized format for the physician's progress notes. The facility plans to develop this format after statewide efforts to standardize all psychiatric monitoring indicators have been finalized.

Recommendation 4, June 2007:
Continue monitoring based on random sample sizes of at least 20%.

Findings:
PSH used the PSH Physician Progress Note Auditing Form to assess compliance with the requirements in D.1.f.i to D.1.f.v and D.1.f.vii, and the PSH Medication Monitoring PRN and Stat Auditing Forms to assess compliance with the requirement in D.1.f.vi. The compliance rates for each of these requirements are listed in each corresponding sub-cell, with the indicators listed only if they represented sub-components of each requirement. The average sample sizes (and months of monitoring) were as follows:

Form used	Average sample size	Months of monitoring
PSH Physician Progress Note Auditing Form	6% of the charts of individuals who have been hospitalized for more than seven days	May-September 2007
PSH Medication Monitoring PRN Auditing Form	3%	August 2007
PSH Medication Monitoring Stat Auditing Form	18%	September 2007

PSH reported that a lack of staffing resources have limited its ability

		to monitor the recommended sample. As mentioned in C.1.a, the facility currently has two full-time acting Senior Psychiatrists and anticipates filling two additional positions by February 1, 2008. At this time, two full-time registered nurse auditors work through the Standards Compliance Department to assist the medical staff in the process of auditing. **Other findings:** Chart reviews by this monitor indicate that, in general, the facility has yet to correct the deficiencies in the documentation of psychiatric reassessments that were listed (#1-8) in this monitor's previous report. Examples of poor documentation are found in the charts of OA (July 2, 2007), LEM (August 28 and September 28, 2007), LC (November 5, 2007), IM (October 30, 2007) and JC (October 30, 2007). Some charts (LER, and WP) included adequate formats for progress note documentation. In general, this format meets EP requirements. However, the content of this documentation requires more work to ensure the following: 1. Appropriate documentation of events during the previous interval; 2. Adequate analysis of the risks and benefits of current treatment and attempts to use safer and effective treatment alternatives; 3. Proactive evaluation of risk factors and timely modification of treatment to minimize the risk; and 4. Critical review of the circumstances leading to PRN/Stat medication use and adjustment of regular treatment as a result of this review. This monitor also reviewed the charts of eight individuals (LC, DC, LARE, BHF, JP, OC, OA and KC) who have experienced the use of seclusion and/or restraints. The purpose of this review was to assess the psychiatric reassessments of the appropriateness of the use of PRN/Stat medications prior to seclusion and/or restraints. This review

		is also relevant to the requirement in D.1.f.vi. The review showed the following general pattern of deficiencies: 1. PRNs were not always ordered and administered when indicated; 2. Multiple PRN medication regimens were ordered for generic indications (e.g. agitation) without clear delineation of the circumstances that would require the use of each of these medications; 3. When PRNs were used, there was no consistent review of the number and the type of medications that were administered, the circumstances that led to their use and the individual's response to this use; 4. There was evidence that regular treatment was adjusted in a timely and appropriate manner based on the use of PRN medications; and 5. In some cases, the documentation of a face-to-face assessment by the psychiatrist did not meet standards of care. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a format for psychiatric reassessments that ensures correction of the deficiencies outlined in this monitor's report and in the previous report. 2. When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific items: a. Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plan; b. Review of individual's progress in behavioral treatment; c. Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and

		d. Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments. 3. Monitor this requirement based on at least a 20% sample and provide data analysis regarding low compliance with corrective actions.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	1. *Subjective complaints are documented* 73% 2. *Identified target symptoms are documented* 48% 3. *Progress towards progress in the WRP is documented* 32% 4. *The mental status examination is documented* 71% 5. *Current status of medical problems and treatment is documented* 18% 6. *Relevant laboratory data are documented* 45%
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	35%
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	No data were presented.
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	19%
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same	1. *Rationale for current psychopharmacology plan is documented* 42% 2. *Response to pharmacologic treatment is documented* 42% 3. *AIMS is completed and documented* 36%

	condition), and conventional and atypical antipsychotic medications;	4. *MMSE is completed and documented*	14%
D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	1. *Order for PRN medication specifies behavioral indications that involve risk, without generic terms*	44%
		2. *Indications for PRN use are documented*	36%
		3. *Rationale for chosen PRN medication is documented*	28%
		4. *Review of PRN medications used during the interval is documented*	24%
		5. *Strategy to modify regular treatment based upon review of use is documented*	24%
		6. *There is documentation that regular treatment is modified based on patterns of PRN use, as appropriate*	27%
		7. *Evidence of symptom reduction and/or improved participation in therapeutic activities as a result of PRN use is documented*	46%
		8. *A psychiatrist conducts face-to-face assessment of the individual within 24 hours of the administration of Stat medication*	78%
		9. *Reason for Stat administration is documented*	67%
		10. *Individual's response to Stat medication is documented*	61%
		11. *As appropriate, adjustment of current treatment is documented*	0%
		12. *As appropriate, adjustment of current diagnosis is documented*	0%
D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with	1. *There is documentation in a verifiably clinically justified manner that psychiatric and behavioral treatments are properly integrated*	34%
		2. *There is documentation that PBS/behavioral plans are*	11%

	psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.	*integrated in clinically justifiable manner*
D.1.g	When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue to monitor using current instrument and ensure random sample of at least 20%. **Findings:** PSH used the PSH Physician Transfer Note Auditing Form (May to October 2007) to assess compliance. The facility reviewed an average sample of 8% of the number of individuals transferred from one unit to another per month. The following is an outline of the indicators and corresponding compliance rates: 1. *Reason for transfer including anticipated benefits of transfer* 16% 2. *Current psychiatric diagnosis* 14% 3. *Psychiatric course of hospitalization* 50% 4. *Medical course of hospitalization and current medical condition* 35% 5. *Current target symptoms* 29% 6. *Psychiatric risk assessment* 31% 7. *Review of medications, including medication trials* 26% 8. *Current barriers to discharge* 23%

		Recommendation 2, June 2007: Ensure that monitoring considers the quality, not just the presence or absence, of documentation. **Findings:** The facility has yet to develop monitoring instructions to ensure implementation of this recommendation. Statewide efforts are underway to standardize and finalize these instructions. **Recommendation 3, June 2007:** Identify barriers to compliance and develop and implement corrective actions. **Findings:** PSH reported that the main barrier is that the format regarding completion of the transfer note has not been available on all units. The facility has a plan of posting the format onto the share drive as a corrective action. **Recommendation 4, June 2007:** Develop tracking system to facilitate monitoring of inter-unit transfers of individuals who present severe management problems to ensure adequate design and implementation of PBS plans prior to transfer. **Findings:** PSH has yet to implement this recommendation. **Other findings:** This monitor reviewed the inter-unit transfer assessments in the charts of six individuals. The following table outlines the individuals reviewed and the dates of transfers:

Initials	Date of transfer
MAF	09/17/07
DAA	10/01/07
OA	08/10/07
JR	06/22/07
RLW	11/07/07
TN	08/21/07

The review showed that the transfer assessment was either missing (MAF and DAA) or did not include the information needed to ensure continuity of care (OA, JR, RLW and TN)

Compliance:
Partial.

Current recommendations:

1. Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the transfer psychiatric assessments correct the deficiencies outlined by this monitor.
2. Monitor this requirement based on a review of at least a 20% sample and provide data analysis regarding low compliance with corrective actions.
3. Develop a tracking system to facilitate monitoring of inter-unit transfers of individuals who present severe management problems to ensure adequate design and implementation of behavioral guidelines/PBS plans prior to transfer.

2. Psychological Assessments		
		Methodology: Interviewed: 1. Four individuals (TA, Program 4, Unit 35; PS, Program 4, Unit 34; LEF, Program 4, Unit 36; and MH) 2. Allison Pate, PhD, Senior Supervising Psychologist 3. David Haimson, PhD, Chief of Psychology 4. Dominique Kinney, PhD, Neuropsychologist 5. Don Brown, RN, PBS 6. Gari-Lyn Richardson, Standards Compliance Director 7. Georgiana Vinson, RN, Standards Compliance Auditor 8. Helga Thordarson, PhD, Senior Supervising Psychologist 9. Jacquelyn Williams, PhD, Psychologist 10. James Kelly, RT, BY CHOICE coordinator 11. Jeff Chambliss, PT, PBS 12. Jeffrey Weinstein, PhD, Psychologist 13. Joseph Malancharuvil, PhD, ABPP, Clinical Administrator 14. Maria Castillo, RN, PBS 15. Melanie Byde, PhD, Mall Director 16. Michelle Sefers, PT, PBS 17. Mona Mosk, PhD, psychologist Reviewed: 1. Charts of 76 individuals: AC, ALH, ARB, ASE, BF, CC, CD, CG, CL, CM, DC, DR, DRD, DRH, DV, EG, EH, ES, EW, FG, GC, GD, GM, GMG, GRE, GSD, HHD, JA, JC, JFN, JG, JLG, JLJ, JML, JN, JR, JRD, JS, JYS, KM, LEM, LF, MAE , MAM, MB, MC, MD, MEK, MW, MWD, NG, NRL, PCS, PP, PT, RL, RLN, RM, RMR, RMT, RP, RPJ, RRS, RT , SAA, SB, SD, SG, SLC, SOG, SP, SRT, TJE, WD, WV, and YB 2. Credentialing/Privileging for Substance Abuse 3. List of Completed DSM-IV-TR Checklists 4. List of Individuals Admitted Prior to June 1, 2006

		5. List of Individuals with Diagnostic Uncertainties 6. List of Individuals Under 1:1 monitoring and/or Restraints/Seclusion 7. List of Individuals whose Primary/Preferred Language is not English 8. List of Psychologists Undertaking Psychological Evaluations 9. List of School-Age Individuals, Needing Cognitive and Academic Assessments Within 30 Days of Admission 10. List Verifying Staff Competency for Specific Mall Groups 11. PSR Mall Curricula 12. PSR Mall Hours of Service by Administrative and Support Staff 13. PSR Mall Hours of Service by Discipline 14. PSR Mall Schedule 15. Psychologists' Curriculum Vitae 16. Verification of Competency for Providing Substance Abuse Groups 17. WRP Mall Alignment Check Protocol <u>Observed</u>: 1. WRPC (Program VIII, unit 25) for BDM 2. WRPC (Program IV, unit 34) for DLG 3. WRPC (Program VI, unit EB-02) for AV 4. WRPC for JL 5. PSR Mall group: Smoking Cessation: You Can Quit 6. PSR Mall group: 64 Ways to Non-Violence (Program III, unit 31)
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Ensure that revised documents or manuals, where applicable, are aligned across DMH hospitals. • Ensure that all psychologists understand and can utilize the new clinical information included in the revised documents or manuals.

	of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	**Findings:** The DMH Psychology Manual is aligned across DMH hospitals. The revised manual has been distributed to psychology practitioners and is in use as of September 2007. According to David Haimson, Chief of Psychology, the revised documents were discussed with the staff. Newly hired psychologists are to be trained in the New Psychologist Seminar. The BY CHOICE and PBS Manuals are still under revision. **Recommendation 3, June 2007:** Ensure that there are sufficient numbers of psychologists to fulfill all requirements of the EP. **Findings:** PSH does not have sufficient numbers of psychologists to provide timely and effective service to individuals in the facility. PSH has hired a number of psychologists since the last Court Monitor review, and continues the hiring process to fill the remaining vacancies. PSH has more than 35 vacant psychology positions. At the time of this review, PSH had a total of 64 psychologists in its system, with most working full-time. Six of the 64 psychologists work in departments other than Psychology or hold other positions. For example, the Clinical Administrator, Mall Director, and Mall Coordinator are psychologists. Only two of the seven Senior Psychologists positions have been filled. **Compliance:** Partial. **Current recommendations**: 1. Ensure that revised documents or manuals, where applicable, are aligned across DMH hospitals. 2. Ensure that there are sufficient numbers of psychologists to fulfill all requirements of the EP.

<table>
<tr>
<td>D.2.b</td>
<td>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</td>
<td>
Current findings on previous recommendation:

Recommendations 1-2, June 2007:
• Ensure that all individuals age 22 or younger have their academic and cognitive assessments conducted within 30 days of admission, unless comparable testing has been performed within one year of admission and is available for review by the interdisciplinary team, or the individuals have graduated from high school or obtained a GED.
• Ensure that individuals who could not be tested within the first 30 days of admission, for medical or other reasons, are documented and followed up to make sure that such evaluations are completed when the individual is ready for assessment.

Findings:
This monitor's review of PSH data showed that 47 individuals under the age of 22 were admitted to PSH in the last six months. Five of the 47 individuals met criteria for cognitive/academic assessments. This monitor reviewed the documentation on the cognitive/academic assessments for these five individuals and found that all five assessments were conducted within the required 30-day time frame. The table below is a summary of the data on the five individuals who met criteria for the 30-day cognitive/academic assessments:

<table>
<tr><td>Initials</td><td>Date of Admission</td><td>Date of Assessment</td></tr>
<tr><td>MD</td><td>April 4, 2007</td><td>May 8, 2007</td></tr>
<tr><td>GM</td><td>April 24, 2007</td><td>May 9, 2007</td></tr>
<tr><td>SRT</td><td>April 24, 2007</td><td>May 18, 2007</td></tr>
<tr><td>CC</td><td>April 5, 2007</td><td>April 27, 2007</td></tr>
<tr><td>MAM</td><td>April 24, 2007</td><td>May 18, 2007</td></tr>
</table>
Compliance:
Full compliance.
</td>
</tr>
</table>

		Current recommendations: Continue current practice.
D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	**Current findings on previous recommendation:** **Recommendations 1-3, June 2007:** • Fill all vacant psychology positions. • Ensure that senior psychologists have the necessary administrative support in their roles of teaching, training and evaluating other psychology staff. • Ensure that senior psychologists have the necessary time to properly mentor and supervise psychology staff. **Findings:** PSH has not filled all vacant psychology staff positions. The facility has hired a number of new psychologists since the last Court Monitor's review. However, the facility still has 35 vacancies. These unfilled positions are affecting the facility's ability to provide quality services in a timely fashion to all its residents. This monitor interviewed David Haimson, Chief of Psychology, and the two Senior Psychologists (Helga Thordarson and Allison Pate). The two Senior Psychologists have the administrative support to carry out their duties. However, both of them are fully engaged in EP tasks and do not have the time to teach, supervise, and train other psychologists as much as they need to. Nevertheless, the Senior Psychologists have been using creative ways of teaching/training staff via newsletters and emails. **Recommendation 4, June 2007:** Standardize assessment formats and report writing templates to make it simpler for psychologists to comply with the EP.

		Findings: According to the Chief of Psychology, PSH's Integrated Psychological Assessment (IPA) was standardized and received DMH approval. The Psychology Focused Assessment (PFA) was revised and submitted for DMH approval. **Recommendation 5, June 2007:** Conduct regular review of assessments to check for compliance and provide corrective feedback as necessary. **Findings:** PSH reviews psychological assessments on a monthly basis. In September 2007, PSH established a 100% monitoring standard for IPAs and achieved a 93% monitoring sample. However, according to the Chief of psychology and Senior Psychologists, corrective feedback of those reviews were not systematically delivered to the psychologists conducting those assessments due to shortage of time for the Senior Psychologists to do so. This monitor's review of psychologists' curriculum vitae and credentialing and status showed that of the 39 of the 64 psychologists at PSH are licensed. Twenty-seven of them have full medical staff privileges, nine have provisional medical staff privileges and 28 are privileged through the psychology department. **Compliance:** Partial. **Current recommendations**: 1. Fill all vacant psychology positions. 2. Ensure that senior psychologists have the necessary time to properly mentor and supervise psychology staff.

		3. Ensure that staff is trained on the Psychology Focused Assessment and fully implemented when the instrument receives DMH approval. 4. Conduct regular review of assessments to check for compliance and provide corrective feedback as necessary.
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	**Compliance:** Partial.
D.2.d.i	expressly state the clinical question(s) for the assessment;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure that the statements of the reasons for referral are concise and clear. **Findings:** PSH audited 94 psychological assessments using item #3 (*All psychological assessments, consistent with generally accepted professional standards of care, shall expressly state the clinical question(s) for the assessment*) from the DMH Psychology Monitoring Form to address this recommendation, reporting 100% compliance. This monitor reviewed 11 psychological assessments (CM, AC, MW, DRD, GD, CL, JR, JRD, ES, CG, and GMG). All 11 of them had the clinical questions expressly stated indicating the reasons for the referral. **Recommendation 2, June 2007:** Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within PSH.

		Findings: PSH did not audit this recommendation. Staff shortage was given as a reason for not auditing this recommendation. This monitor reviewed 11 charts (CM, AC, MW, GD, CL, DRD, JR, JRD, ES, CG, and GMG). Nine of them (CM, MW, GD, CL, DRD, JR, ES, CG, and GMG) evidenced continuity among the sections in the report, linking the referral questions to the recommendations and therapies. Two of them (AC and JRD) did not have proper continuity among the sections. **Recommendation 3, June 2007:** Use the newly standardized focused assessment template. **Findings:** PSH audited 94 Focused Psychological Assessments to evaluate if the reports utilized the newly approved DMH template, reporting 94% compliance. This monitor reviewed nine Focused Psychological Assessments (MW, CM, AC, GD, JR, JRD, ES, CG, and GMG). All of them had used the new template. **Current recommendations**: Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within PSH.
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure that psychologists fulfill this requirement.

		Findings: PSH audited 94 assessments using item #4 (*All psychological assessments, consistent with generally accepted professional standards of care, shall include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations*) from the DMH Psychology Monitoring form to address this recommendation, reporting 99% compliance. This monitor reviewed eight Focused Psychological Assessments (MW, AC, CM, JR, JRD, ES, CG, and GMG). All eight of them included information that met criteria to fulfill this recommendation. **Recommendation 2, June 2007:** Use the correct structure and format for conducting assessments. **Findings:** PSH psychologists are using the newly approved DMH psychological assessment template with standardized structure and format. This monitor reviewed eight assessments (CM, AC, MW, JR, JRD, ES, GMG, and GC) and all eight had followed the structure and format following the newly approved DMH template. **Current recommendations**: Continue with the current practice of including findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Ensure that all psychological assessments include findings and recommendations pertaining to the individual's participation in therapeutic services.

		Findings: PSH audited 94 Focused Psychology Assessments using item #5 (*All psychological assessments, consistent with generally accepted standards of care, shall specify whether the individual would benefit from individual or group therapy in addition to attendance at mall groups*) from the Psychology Monitoring form to address this recommendation, reporting 78% compliance. According to the Chief of Psychology and the Senior Psychologists, compliance with this requirement is expected to improve since the new psychology interns (responsible for conducting many of the assessments), training directors, supervisors and unit psychologists were made aware of this requirement. This monitor reviewed ten Focused Psychological Assessments (AC, MC, CL, DRD, JR, JRD, CG, GD, ES, and GMG). Seven of them (AC, MC, CL, DRD, JR, JRD, and CG) of them addressed the individual's participation in individual and or group therapy, in addition to their attendance at Mall groups. Three of them (GD, ES, and GMG) failed to fully address this recommendation. **Current recommendations**: Ensure that all psychological assessments include findings and recommendations pertaining to the individual's participation in therapeutic services.
D.2.d.iv	be based on current, accurate, and complete data;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue and improve on current practice.

		Findings: PSH audited 94 Focused Psychological Assessments using item #6 (*All psychological assessments, consistent with generally accepted professional standards of care, shall be based on current, accurate, and complete data*) from the DMH Psychology Monitoring Form, reporting 84% compliance. According to the Chief of Psychology and the Senior Psychologists, the lower compliance rate obtained at this audit (the July 2007 audit compliance rate was at 98%) was due to a few assessments that required a quick turnaround time. The 'Background History' section on a few of these assessments was recorded as "Not Applicable" and referred the reader to other sources for the information. These assessments were not given credit towards compliance with this recommendation. The Senior Psychologists have given feedback on this to the staff concerned. This monitor's review of the assessment template and its instructions showed that the section on 'Background History' requires examiners to "Include only those areas relevant to clinical questions." The auditors did not indicate if the "Not Applicable" statements were found across all items under the section or only for those deemed not relevant to the referral/clinical question. Sticking to the instructions will save time (as one of the complaints is that there is not enough time to complete all sections due to the quick turnaround time required for some individuals). This monitor reviewed 14 Focused Psychological Assessments (AC, MW, CM, DRD, GD, CL, JRD, CG, GMG, GG, ES, JR, MG, and FC). Eleven of them (AC, MW, CM, DRD, GD, CL, JRD, CG, GMG, GG, and ES) met the requirements. Three of them did not meet the criteria (MG, FC, and JR). For JR, the section on "Sources of Information" was incomplete; for FC, most of the sections under "Pertinent Background Information"

		was recorded as "No Change" (this is an odd statement given that one would not expect 'change' on background information); and for MG, the section under "Sources of Information" was incomplete, and all items under "Pertinent Background Information" were left blank. **Current recommendations:** Continue and improve on current practice.
D.2.d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement. • Ensure that psychologists conducting assessments attend to this item. **Findings:** PSH audited 94 Focused Psychological Assessments using item #7 (*All psychological assessments, consistent with generally accepted professional standards of care, shall determine whether behavioral supports or interventions, e.g., behavior guidelines or mini behavior plans are warranted or whether a full positive behavior support plan is required*) from the DMH Psychology Monitoring Form, reporting 72% compliance. According to the Senior Psychologists, the compliance rate will improve as the new interns (who conduct many of the assessments), training directors, supervisors and unit psychologists have received training regarding this recommendation. PSH has taken other steps to familiarize examiners with this requirement, including a summary of EP requirements distributed to psychologists by Helga Thordarson, training of new staff by the Chief of Psychology, and including the information in the monthly Psychology Newsletter.

		This monitor reviewed 11 Focused Psychological Assessments (JR, JRD, ES, CG, GMG, AC, MW, CM, CL, GD, and DRD). Seven of them (AC, MW, CL, JR, ES, CG, and GMG) addressed the relevant elements of this recommendation, and four of them (CM, GD, DRD, and JRD) did not. **Current recommendations**: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.
D.2.d.vi	include the implications of the findings for interventions;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation. **Findings:** PSH audited 94 Focused Psychological Assessments using item #8 (*All psychological assessments, consistent with generally accepted professional standards of care, shall include the implications of the findings for interventions*), from the DMH Psychology Monitoring Form, reporting 100% compliance. This monitor reviewed eight Focused Psychological Assessments (AC, MW, CM, JR, JRD, ES, CG, and GMG). All eight included information on the implications of their findings for intervention. **Current recommendations**: Continue current practice.
D.2.d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate,	**Current findings on previous recommendations:**

	specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	**Recommendation 1-3, June 2007:** • Ensure that all psychological assessments meet this requirement. • Ensure that WRP teams review and include appropriate recommendations in the individual's Wellness and Recovery Plan. • Ensure that additional workups are completed as requested. **Findings:** PSH audited 94 Focused Psychological Assessments using item #9 (*All psychological assessments, consistent with generally accepted professional standards of care, shall identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, record review, interviews, or re-evaluations that should be performed or considered to resolve such issues*) from the DMH Psychology Monitoring Form, reporting 74% compliance. PSH did not audit the second recommendation, suggesting "This recommendation belongs to Section C2." This recommendation has been in this section from the beginning, and is directly tied to Recommendation #1. This recommendation should be audited in the future until the criterion is met. This monitor reviewed 11 charts (AC, MW, CM, DRD, CL, GD, JR, JRD, ES, CG, and GMG). Six of them (AC, MW, CM, JRD, ES, and CG) identified inconsistencies found in the information gathered and recommended further action to resolve the identified inconsistencies, whereas five of them (DRD, CL, GD, JR, and GMG) failed to identify inconsistencies and/or recommend further action to resolve the inconsistencies. This monitor reviewed nine charts (SRT, CC, RM, JR, MAN, LEM, MD, MAM, and GM). Two of the WRPs in the charts (SRT and CC) had appropriate information from the assessments in the Present Status section and/or had a foci, objective, and interventions as recommended

		in the assessments. Seven of them (MAM, RM, JR, MAN, LEM, MD, GM) failed to include or fully incorporate the information from the assessments. **Current recommendations**: 1. Ensure that all psychological assessments meet this requirement. 2. Ensure that WRP teams review and include appropriate recommendations in the individual's Wellness and Recovery Plan. 3. Ensure that additional workups are completed as requested.
D.2.d. viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Continue and improve upon current practice. • Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed. **Findings:** PSH audited 94 Focused Psychological Assessments using item #10 (*All psychological assessments, consistent with generally accepted professional standards of care, shall use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing*) from the DMH Psychology Monitoring Form, reporting 83% compliance. According to the Chief of Psychology and the Senior Psychologists, the quality obtained at this review is equal to the previous audit. The decrease in compliance (the compliance at the previous review was 100%) is attributed to changes made to the Monitoring Form and the PFA template. An additional condition was added to the monitoring form requiring the examiners to justify usage of tests not found in the DMH Clinical Indicator List. The Senior Psychologist, Helga

		Thordarson, identified the error and gave feedback to the staff. The feedback seems to have been effective as the compliance rate increased to 100% (October 2007). This monitor reviewed eight Focused Psychological Assessments (JR, CL, AP, JRD, ES, GMG, CG, and JR). All eight contained information indicative of meeting American Psychological Association Ethical Guidelines. All of them completed the demographic and identifying information of the individual being assessed, had documented statements of confidentiality, used test instruments appropriate to address the referral/clinical questions, and the test instruments were from the DMH Clinical Indicator List. This monitor is unable to verify if the administration of the instrument and scoring of the individual's responses were in accordance with the User Manual. **Current recommendations**: Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed.
D.2.e	Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.	**Current findings on previous recommendation:** **Recommendations 1-3, June 2007:** • Ensure that psychological tests are completed in a timely manner, as specified in the EP. • Ensure that reports meet acceptable quality. • Review all psychological assessments of all individuals residing at PSH who were admitted prior to June 1, 2006, and complete further assessments as required by the EP. **Findings:** PSH did not audit this recommendation. According to the Chief of Psychology and the Senior Supervising Psychologist, the facility has not reviewed and/or revised psychological assessments of individuals

		admitted at PSH prior to June 1, 2006. Staffing shortage in the face of all other responsibilities (psychological assessments and services, and EP tasks) was the reason given for failing to address this recommendation. PSH is finding it difficult to complete all required Integrated Psychological Assessments for current admissions. PSH's survey showed that only 42% of the required IPAs were completed. However, PSH has taken steps to address this recommendation by getting staff to work an additional ten hours per week to complete all IPAs. This monitor reviewed nine charts of individuals admitted prior to June 2006 (SP, PCS, JA, JLG, SLC, NRL, RT, EW, and JN). Eight of the IPAs in these charts (SP, PCS, JA, JLG, SLC, RT, EW, and JN) were not reviewed or did not have an updated IPA. One of them (NRL) had an updated IPA (December 10, 2006). However, four of them (SP, NRL, RT, and EW) have had Focused Psychological Assessments, despite not having an IPA, indicating that individuals in need of further assessment are receiving the services through their WRPT reviews. **Compliance:** Partial. **Current recommendations:** 1. Ensure that psychological tests are completed in a timely manner, as specified in the EP. 2. Ensure that reports meet acceptable quality. 3. Review all psychological assessments of all individuals residing at PSH who were admitted prior to June 1, 2006, and complete further assessments as required by the EP.
D.2.f	Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically	**Compliance:** Partial.

<table>
<tr><td></td><td>indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:</td><td></td></tr>
<tr><td>D.2.f.i</td><td>before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:</td><td>Current findings on previous recommendation:

Recommendations 1-2, June 2007:
• Ensure that integrated psychological assessments are conducted in a timely manner as required.
• Hire additional psychologists to ensure timely psychological assessments of individuals.

Findings:
PSH audited 419 charts using item #12 from the DMH Psychology Monitoring Form, reporting 49% compliance. The table below with its monitoring indicator showing the number of new admits requiring the 5-Day Integrated Psychological Assessments needed for each month (N), the number of charts audited (n), and the percentage of charts with the completed 5-Day assessments (%C) is a summary of the facility's data.

Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.

<table>
<tr><td></td><td>5/07</td><td>6/07</td><td>7/07</td><td>8/07</td><td>9/07</td><td>10/07</td><td>Mean</td></tr>
<tr><td>N</td><td>108</td><td>91</td><td>140</td><td>89</td><td>111</td><td>121</td><td></td></tr>
<tr><td>n</td><td>52</td><td>46</td><td>69</td><td>45</td><td>103</td><td>104</td><td></td></tr>
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		<table><tr><td>%S</td><td>48</td><td>50</td><td>49</td><td>5 1</td><td>93</td><td>86</td><td></td></tr><tr><td>%C #12</td><td>65</td><td>54</td><td>48</td><td>44</td><td>50</td><td>42</td><td>49(timely) 66(total completed)</td></tr></table> According to the Senior Psychologist, Helga Thordarson, though the compliance at this review (49%) was higher than the previous review (29%), it is lower than she had expected. The Senior Psychologist cited higher-than-usual admissions in June and July 2007, vacationing by many Admission Unit psychologists in August 2007, and a loss of 23 trainees who completed their internship in August 2007 as reasons for not having a higher compliance. PSH has continued to hire psychologists. A review of the staffing pattern showed that the vacancy rate has decreased from 45% (June 2007) to 37% (November 2007). PSH has 64 psychologists (FTE of 59.75). However, six of the 64 psychologists function in other capacities besides providing psychological assessment/treatment services. This monitor reviewed 20 charts (DRN, YB, TJE, SAA, RMR, EH, ALH, MEK, JLJ, NG, RMT, PP, BF, KM, EG, JML, GRE, SD, SG, and SB). Eight of them (PP, EG, KM, ALH, NG, GRE, SG, and EH) were timely, six of them were present but untimely (JML, MEK, JLJ, SB, YB, and DRN), and six of them were not present (BF, RMT, SD, TJE, SAA, and RMR). **Current recommendations**: Ensure that integrated psychological assessments are conducted in a timely manner as required.
D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service	**Current findings on previous recommendation:**

planning process;

Recommendations 1-2, June 2007:

- Consider all elements that would affect understanding of an individual's psychological functioning when evaluating this item.
- Ensure accurate evaluation of psychological functioning that informs WRPTs of the individual's rehabilitation service needs.

Findings:

PSH used item #14 from the DMH Psychology Monitoring Form to address this recommendation, reporting 59% compliance. The table below with its monitoring indicator showing the number of new admits requiring the 5-Day Initial Psychological Assessments needed for each month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.

	5/07	6/07	7/07	8/07	9/07	10/07	Mean
N	108	91	140	89	111	121	
n	52	46	69	45	103	104	
%S	48	50	49	5 1	93	86	
%C #14	67	52	58	58	63	57	59

This monitor reviewed 13 charts (PP, KM, EG, JML, GRE, SB, NG, JLJ, ALH, EH, JFN, DRH, and YB). Nine of them (KM, EG, JML, GRE, NG, JLJ, ALH, EH, and DRH) provided information on the individual's psychological functioning in practical terms from which the individual's WRPT can determine the nature of rehabilitation interventions for the individual. Four of them (YB, JFN, SB, and PP) did not provide sufficient information.

		Current recommendations: Ensure accurate and complete evaluation of an individual's psychological functioning that informs the WRPTs of the individual's rehabilitation service needs.
D.2.f.ii	if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Ensure that unit staff is familiar with referral criteria to the PBS team when individuals have significant learned maladaptive behaviors that are not amenable to intervention with behavior guidelines. **Findings:** This monitor spoke with WRPC team members and unit staff. All of them were familiar with the process of making PBS referrals. Many of them indicated that PBS team members attend WRPCs to talk about the PBS process as well as assist the WRPT members in documenting PBS plans. PSH has taken many steps to ensure that unit staff is familiar with PBS procedures and processes. PBS teams had trained unit staff (February 7 and 8, 2007) on PBS referral procedures. Allison Pate, Senior Supervising Psychologist, has distributed a summary guide ("Guide to Behavioral Interventions") too all staff (November 9, 2007). The process was also clarified in the monthly psychology newsletter. New psychologists are trained on the PBS-BCC checklist (the checklist is utilized for all PBS consultations) during the New Psychologist Seminar, facilitated by the Chief of Psychology. PBS team members consult with unit psychologists when the latter develop behavior guidelines. **Recommendation 2, June 2007:** Ensure that PBS referrals get timely attention to assist unit staff to manage individuals with significant learned maladaptive behaviors.

		Findings: According to the Chief of Psychology and the PBS team members, PSH has set up a system to ensure that PBS referrals get a response within 24 hours. PSH currently has two active PBS plans. A review of the dates of PBS-BCC checklist referral made to the PBS team and the date of response from the PBS team to the referral source showed that the responses were timely. All referrals to the PBS teams come through PBS-BCC checklist. According to the PBS coordinator, Susan Velasquez, the referrals are entered into a database and are reviewed and prioritized by the team, based on the intensity of the maladaptive behaviors. PBS teams will have difficulty responding in a timely fashion to referrals should the number of referrals increase. PSH has three functioning PBS teams (two full teams and one partial team). The current staff to resident ratio is 1:504 and not 1:300 as required by the EP. **Recommendation 3, June 2007:** Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist. **Findings:** According to the Chief of Psychology and the PBS chair, Structural and Functional Assessments are conducted by PBS psychologists. All PBS team leaders, psychologists, are credentialed. PBS team members are trained in PBS principles and procedures. Unit psychologists write behavioral guidelines with support from PBS team members. Formal structural and functional assessments are only conducted for PBS plans. PBS team members receive ongoing training from their CRIPA consultant, invited speakers, and through conferences/seminars offered outside the facility.

		Current recommendations: Ensure that PBS referrals get timely attention to assist unit staff to manage individuals with significant learned maladaptive behaviors.
D.2.f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure that additional psychological assessments are performed as required in this cell. **Findings:** PSH used items #16, #17, #18, #19, #20, and #21 from the DMH Psychology Monitoring Form to address this recommendation, reporting 40%, 34%, 70%, 33%, 78%, 22% compliance respectively. The table below with its monitoring indicators showing the number of IPAs audited per month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data. *Additional psychological assessments are performed, as appropriate, where psychological information is otherwise insufficient (#16).* *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "differential diagnosis (#17).* *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "rule-out" (#18).* *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "deferred" (#19).* *Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "no-diagnosis" (#20).*

Additional psychological assessments are performed, as appropriate for diagnostic questions, specifically "NOS diagnoses" (#21).

	7/07	8/07	9/07	10/07	Mean
n	13	12	18	7	
%C #16	62	42	28	29	40
n	5	7	14	6	
%C #17	40	43	29	33	34
n	3	3	4	-	
%C #18	67	67	75	-	70
n	2	3	5	5	
%C #19	0	67	40	20	33
n	11	11	24	4	
%C #20	82	91	71	75	78
n	3	1	8	6	
%C #21	33	0	12	33	22

This monitor reviewed 12 charts (GSD, EG, RLN, CL, RRS, WD, JYS, DV, SOG, RP, FG, and LF). Two of them (GSD and EG) had conducted additional testing to clarify diagnostic uncertainties. The remaining ten (RLN, CL, RRS, WD, JYS, DV, SOG, RP, FG, and LF) did not request and/or follow up with the necessary testing in a timely manner.

Recommendations 2-3, June 2007:

- Ensure that the facility's monitoring instrument that addresses "no diagnosis" is aligned with the key requirement, i.e. that "no

		diagnosis" is backed up by clinical data, especially in individuals with forensic issues. • Ensure that supporting documents are recorded and referenced when using previous assessment results to address diagnosis-related matters. **Findings:** This monitor reviewed 11 charts (MWD, PP, DR, LEM, MB, CG, JR, GC, RP, AC, and RM) with a "No Diagnosis" in one or more of the individual's DSM axes. Seven of them (MWD, PP, DR, LEM, MG, CG, and JR) had appropriate recommendations for follow-up assessments, and the assessments had been conducted in a timely manner. In one of them (RM), the follow-up assessment was conducted but was untimely. Three of them (GC, RP, and AC) did not have any evidence in the charts to show that the assessments were conducted. **Current recommendations:** 1. Ensure that additional psychological assessments are performed as required in this cell. 2. Ensure that the facility's monitoring instrument that addresses "no diagnosis" is aligned with the key requirement, i.e. that "no diagnosis" is backed up by clinical data, especially in individuals with forensic issues. 3. Ensure that supporting documents are recorded and referenced when using previous assessment results to address diagnosis-related matters.
D.2.g	For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the	**Current findings on previous recommendations:** **Recommendations 1-3, June 2007:** • Ensure that assessments conducted meet this requirement. • Ensure that individuals have access to providers who can communicate with the individuals in their preferred/primary mode

use of interpreters in the individual's primary language and dialect, if feasible.

of language and communication.

- Ensure the availability of translation or interpretation services for non-English-speaking individuals and individuals with communication disabilities.

Findings:

PSH used item #22 from the DMH Psychology Monitoring Form to address this recommendation, reporting 44% compliance.

The table below with its monitoring indicator showing the number of IPAs of individuals whose primary/preferred language is not English (N), the number of IPAs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

For individuals whose primary/preferred language is not English, there is documentation that the psychologist has endeavored to assess them in their own language.

	5/07	6/07	7/07	8/07	9/07	10/07	Mean
N	5	1	1	1	2	6	
n	5	1	1	1	2	6	
%S	100	100	100	100	100	100	
%C #22	20	100	0	0	50	66	44

PSH has a system in place to provide necessary resources to address language/communication needs of individuals in its facility. PSH has a specialized hearing- impaired unit staffed with providers proficient in American Sign Language (ASL). PSH also has a Spanish-speaking team staffed by numerous Spanish-speaking providers.

A review of documents by this monitor showed that PSH maintains a list of multi-lingual providers to call upon when their services are needed to assess/treat individuals with language/communication needs. According to the Chief of Psychology, PSH has a contract with AT&T

		for contract interpreter service. This monitor reviewed nine charts of individuals (JG, CG, LEM, SOG, JC, WV, GD, ASE, and JS) whose primary/preferred language is not English. Six of them were (GD, JG, CG, LEM, WV, and ASE) assessed in the individuals primary/preferred language/mode of communication. Five of them were Spanish-speaking and they were evaluated by Spanish-speaking examiners, and one used ASL and was evaluated by an ASL interpreter. The remaining three (SOG, JC, and JS) did not have IPAs in their charts. **Compliance:** Partial. **Current recommendations:** Ensure that assessments conducted meet the requirement for this cell.

3. Nursing Assessments		
		Methodology: Interviewed: 1. Regina Olender, Coordinator of Nursing Services/Nurse Administrator 2. Tatiana Rojas, RN, Standards Compliance Auditor 3. Caroline Pangan, RN, Standards Compliance Auditor 4. Crystal Borck, RN, Standards Compliance Auditor Reviewed: 1. PSH progress report and data 2. PSH Enhancement Plan Nursing Activities 3. Admission Nursing Assessment RN Competency Evaluation sample audits 4. Training rosters for Nursing Assessment Competency Evaluation training 5. Staff Development training report for Admission Nursing Assessment competency database 6. NP 301, Nursing Assessment: Admission, Integrated, Annual, and Updated 7. NP 302, Nursing Application of the Wellness and Recovery Plan 8. NP 303, Recovery Focused Documentation 9. Admission and Integrated Assessments for the following individuals: PJC, JJC, DD, JVD, AH, JAG, MPH, EI, RK, WR, KES, SLF, JEF, JCC, DLA, HC, ES, GHS, JOS, CDS, JS, JT, MAT, CW, JMK, SJ, DAA, BWB, MJB, ATC, JRD, AMG, NSG, GDM, JQ, ARR, EJR, PJS, RD, RBC, MC, AAC, JW, VF, ECE, MED, VMD, TAM, JML, BH, CRB, AO, JTM, JR, CH, DAC, ECS, DLS, JTW, BGE, THE, MWF, CMF, GH, DR, BNL, JL, AAM, EM, PS, NSO, HDS, GPS, WRM, MG, SAA, LS, SH, AMA, CMA, TBA, DEB, FC, ALH, DRH, EAJ, KMc, CM, JFN, SP, JMP, RMR, RRS, JYS, PW, and TLW

D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	**Compliance:** Partial.
D.3.a.i	a description of presenting conditions;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Develop and implement monitoring instruments and a tracking system addressing all elements of this requirement. **Findings:** The Statewide Nursing Services Group has revised the Nursing Admission Assessment and Integrated Assessment as well as the monitoring tools. PSH implemented the new nursing assessments during this review. Data from PSH's progress report reflect the existing assessment process. By the next review, data should be generated from the new assessments and monitoring tools. In addition, PSH will track the data using the PLATO System. **Recommendation 2, June 2007:** Ensure that nursing staff is competent in the protocols addressing this requirement. **Findings:** PSH's progress report and training rosters indicated that between May and October, six new nursing employees received training in the Science of Forensic Psychiatric Nursing and were determined to be competent in the protocols for completing the Admission and Integrated Nursing Assessments. In addition, in July the facility implemented a system in which a nursing supervisor conducts an Admission Assessment Competency Evaluation with the RN conducting the assessment.

		Recommendation 3, June 2007: Ensure that nursing staff adequately tracks, documents and monitors this requirement. **Findings:** PSH's Nursing Admission Assessments Monitoring data from May to October 2007, based on an average sample size of 71% of admissions, indicated 47% compliance with documentation of the presenting complaint on the Nursing Admission Assessments. The data indicated a dramatic decrease from 99% compliance in May to 5% in August. In an interview, the Nurse Administrator reported that the Standards Compliance auditor was changed in August. The new auditor was trained to have a higher expectation of quality as required by the Enhancement Plan. The Nurse Administrator felt that the 5% compliance rate was an accurate representation of the documentation. **Other findings:** In most of PSH's data in this section, compliance rates were consistently lower from August through October 2007 than in prior months. This decrease is related to the change in auditors from the Nursing Department to Standards Compliance. However, the lower compliance rates appear to be more reflective of the actual practices in the nursing department. From my review of 96 nursing admission and integrated assessments, I found that 82 contained superficial documentation regarding the presenting condition on admission. Most of the documentation was not individualized and did not include any type of description of the individual during the admission process. Overall, I found that the vital signs, allergies, pain assessment, use of assistive devices, activities of daily living, immediate alerts, and conditions needing immediate nursing

		interventions were adequately documented. I found that 80 of the admission assessments did not include all of the criteria related to currently prescribed medications, such as the date the last dose was taken. The superficial documentation regarding the presenting condition rendered a majority of the assessments to be of poor quality. This finding is particularly concerning since the new nursing assessment is longer and requires more details. **Current recommendations:** 1. Ensure that nursing is provided training on the use of the new admission and integrated assessment forms. 2. Provide data regarding competency for existing staff regarding protocols addressing this requirement. 3. Continue to monitor this requirement.
		The following data is the mean compliance rate from PSH's progress report from the Nursing Admission Assessment Monitoring for May-October 2007 for each item:
D.3.a.ii	current prescribed medications;	20.6%
D.3.a.iii	vital signs;	90%
D.3.a.iv	allergies;	78.9%
D.3.a.v	pain;	93.5%
D.3.a.vi	use of assistive devices;	89.7%
D.3.a.vii	activities of daily living;	95.2%
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide	70.3%

	risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	
D.3.a.ix	conditions needing immediate nursing interventions.	77.4%
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue to revise policies and procedures to include WRP language. **Findings:** Revisions in Nursing Policy & Procedure 301, Nursing Assessment: Admission, Integrated, Annual, & Update adequately reflected the Enhancement Plan requirements and WRP language. In addition, NP 302, Nursing Application of the Wellness and Recovery Plan and NP 303, Recovery Focused Documentation are currently being reviewed. **Recommendation 2, June 2007:** Ensure that nursing assessments, integrated nursing assessments and documentation in the progress notes reflect Wellness and Recovery principles. **Findings:** Same as above. **Recommendation 3, June 2007:** Continue to provide nurses training regarding the WRP system. **Findings:** As of 11/7/07, data from PSH indicated that 36% of RNs, 32% of Psychiatric Technicians (PTs), and 21% of LVNs have had WRP training. Staffing issues were cited as the reason that a majority of nursing/PT

		staff have not yet been trained. This lack of staff training at the unit level supports the overall finding that changes in the system thus far have not significantly impacted practice. At the time of this review, the majority of nursing/PT staff has not had training to fundamentally understand the shift in philosophy in caring and providing services to the individuals at PSH. Efforts need to be made to provide training to all staff regarding Wellness and Recovery. **Compliance:** Partial. **Current recommendations**: 1. Continue revising Nursing Policies & Procedures to include WRP language. 2. See C.1.a, Recommendation 3. 3. Continue to monitor this requirement.
D.3.c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Metropolitan State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue the development of and implement a monitoring instrument and tracking system to adequately address all elements of this requirement. **Findings:** Staff Development Training Records adequately track, document and monitor this requirement. **Recommendation 2, June 2007:** Develop, initiate and document regular monitoring, at least quarterly, of nursing assessment competency.

		Findings: See D.3.a.i **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	**Compliance:** Partial.
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Present complete data information regarding this requirement. **Findings:** The data provided by PSH regarding this requirement was complete. **Recommendation 2, June 2007:** Continue to monitor this requirement. **Findings:** PSH's data indicated that based on an average sample of 82.6% from May-October 2007, Nursing Assessments were completed within 24 hours 94% of the time. Similarly, from my review of 96 Nursing Assessments, I found that only five were not completed within 24 hours.

		Current recommendation: Continue to monitor this requirement.
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	**Current findings on previous recommendation:** **Recommendation, June 2007:** See D.3.d.i. **Findings:** See D.3.d.i. **Other findings:** PSH's data for May-October 2007 indicated, based on an average sample of 82%, that 55% of the Integrated Assessments were completed within five days. (PSH policy indicates a five-day time frame for completion of Integrated Assessments rather than a seven-day time frame.) The facility reported that staffing issues were the cause of the lack of timeliness. From my review of 96 Integrated Assessments, I found that 56 (58%) were completed within five days. **Current recommendation**: Continue to monitor this requirement.
D.3.d.iii	Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.	**Current findings on previous recommendation:** **Recommendation, June 2007:** See D.3.d.i. **Findings:** See D3.d.i.

Other findings:
PSH's WRP Observation Monitoring data for May-October 2007, based on a 17% sample of conferences scheduled each month, indicated:

RNs participated in the WRPC by presenting or updating discipline-specific and/or holistic assessment data	3.6%
RNs presented MOSES data at the WRPC	2.7%
RNs presented relevant and appropriate content for the discipline-specific assessments	2.5%
The implications of assessments results and consultations for diagnosis, therapy and rehabilitation were communicated by the RN in the WRPC	0.7%

PSH's progress reported indicated that the low compliance rates for WRP training for nursing staff was adversely affecting the performance of the nursing staff at the WRPCs. However, from my interviews, there was no plan in place to address this issue. In addition, due to staffing patterns and conference scheduling, many of the RNs who attend the conferences are not the ones who have worked with or been assigned to the individuals. Consequently, they are not familiar with the assessments or the individuals' WRPs.

Current recommendations:
1. See C.1.a, Recommendation 3 re training.
2. Evaluate staffing patterns and conference schedules to ensure appropriate and consistent staff are present at WRPCs.
3. Continue to monitor this requirement.

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Greg Siples, Chief of Rehabilitation Services 2. Brian Starck-Riley, Clinical Dietitian 3. Denise Byerly, RN, Dysphagia Team Coordinator 4. Michael Gomes, Recreation Therapist 5. G. Michelle Reid-Proctor, MD, Physical Medicine and Rehabilitation 6. Janet Richards, Occupational Therapist 7. Mark Camero, Supervising Rehabilitation Therapist 8. Jacqueline Doss-Haynes, Supervising Rehabilitation Therapist 9. Tai Kim, Director of Nutrition Services 10. Kurt Reich, Program Director 11. Roger Rhodes, Occupational Therapist 12. Victor G. Ruiz, Speech Pathologist 13. Jerry Marquez, Physical Therapist Assistant 14. Louis F. Lacouette, Physical Therapist 15. Billy Mange, Senior Vocational Rehabilitation Counselor 16. Jay Gehrke, Industrial Therapist 17. Lorraine A. Nicklin, Teacher 18. Joseph Malancharuvil, Clinical Administrator 19. Melanie Byde, PhD, Acting Mall Director Reviewed: 1. PSH Rehabilitation Therapy Manual 2. Integrated Assessment-Rehabilitation Therapy 3. Integrated Assessment-Rehabilitation Therapy instructions 4. DMH Rehabilitation Therapy Audit 5. DMH Rehabilitation Therapy Audit Instructions 6. DMH Rehabilitation Audit data for June-October 2007 7. PSH Summary of IART Pilot Project 8. Email correspondence regarding IART pilot and revised tools

		9. Occupational Therapy Initial Evaluation tool 10. Physical Therapy Initial Evaluation tool 11. List of speech, language, articulation, voice, aphasia, dysarthria, apraxia, and dysphagia standardized and structured assessments 12. List of Rehabilitation Therapy Standardized Assessments 13. Gait Safety Assessment 14. Wheelchair Assessment form 15. Feeding and Swallowing/Dysphagia assessment tool 16. AD #10.18 Physical/Occupational Therapy Services (implemented 7/15/07) 17. AD #10.27 Speech Pathology and Audiology (implemented 6/18/07) 18. AD #10.44 Aspiration and Dysphagia Management (implemented 7/15/07) 19. AD #10.45 Use of Wheelchairs 20. Monthly Wheelchair Maintenance Checklist 21. Wheelchair Repair Request 22. AD #10.01 PSH Clinics, Consultants and Referral Services 23. Careerscope literature 24. IT Work Assignment Application 25. IDT Request form 26. MH 5723 (referral form) 27. Vocational Aptitude Testing process 28. Vocational Services Discharge Summary assessment tool 29. Vocational Rehabilitation Services Application 30. Vocational Health Questionnaire 31. Employment Record form 32. Vocational Rehabilitation consent release forms 33. Vocational Interview Summary 34. I.T. Work Assignment Application 35. AD #17.03 Industrial Therapy Assignments 36. V.I.C.T.O.R.Y Proposal Manual 37. Dysphagia and Aspiration Management Comprehensive Assessment tool

		38. Dysphagia and Aspiration Identification and Support Processes flow sheet 39. Aspiration and Dysphagia Risk Pre-screening Assessment 40. Dysphagia and Aspiration Management Monitoring Tool 41. Nursing Policy and Procedure 319: Dysphagia and Aspiration Management (implemented 4/07) 42. PSH Post-choking Assessment 43. Choking/Aspiration Post-Incident Evaluation 44. List of individuals who had an Integrated Rehabilitation Therapy Assessment from August-October 2007 45. Records of the following individuals who had Integrated Rehabilitation Assessments from August-October 2007: JMP, ODS, JAG, JRD, JSL, HWS, SGA, NG, JMB, TAM, DDM, AH, SH 46. IA-RTS pilot assessments and corresponding WRPs for the following individuals: SB, CDC, MTM, KCL, DC, JRP, ABT, MSG, ECE, LEJ 47. List of individuals who had a Comprehensive Assessment for Dysphagia and Aspiration Management from May-October 2007 48. Assessments and corresponding WRPs of the following individuals who had a Comprehensive Assessment for Dysphagia and Aspiration Management from May-October 2007: JJD, RWT, DWL, JCB, JLT, RB, RH, AAA, WPW, MDB 49. List of individuals who had Occupational Therapy assessment/consultation from May-October 2007 50. Assessments and corresponding WRPs of the following individuals who had Occupational Therapy assessment/consultation from May-October 2007: NGF, RCG, RRL, MJC, JB, CC, MAT 51. List of individuals who had Physical Therapy assessment/consultation from May-October 2007 52. Records for the following individuals who had Physical Therapy assessment/consultation from May-October 2007: JM, VA, BMP, MN, FC, VQ, KS, JD, JM, AW 53. List of individuals who had Speech Therapy

		assessment/consultation from May-October 2007 54. Assessments and corresponding WRPs for the following individuals who had Speech Therapy assessment/consultation from May-October 2007: AB, CC, CMF, DAR, HLS, BMP, CAW, DLW 55. Vocational Assessments for the following individuals who had a Vocational Assessment from May-October 2007: MD, CC
D.4.a	Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Evaluate completed Integrated Rehabilitation Therapy Assessments to ensure the assessments provide comprehensive information. **Findings:** The Integrated Rehabilitation Services Assessment was revised in order to ensure that the assessment met the requirements of the Enhancement Plan. Structured activities and Rehabilitation Therapy interdisciplinary collaboration were added to the assessment process. The restructuring of the assessment tool and instructions was done with the other three state facilities, with a statewide meeting held on 9/21/07. A pilot of the revised Integrated Assessment-Rehabilitation Services was completed in September and October for a sample of admission assessments. The pilot was structured so that the assessment was completed by a team of two to five Rehabilitation Therapy team members of different disciplines. **Recommendations 2 and 3, June 2007:** • Continue to review and revise policies, procedures, and therapy manuals for alignment with the EP. • Continue to monitor this requirement. **Findings:** New versions of the Administrative Directive procedures for

		Physical/Occupational Therapy Services, Speech Pathology & Audiology, Aspiration & Dysphagia Management, Use of Wheelchairs, and PSH Clinics, Consultant, and Referral Services were developed and implemented between May-October 2007, according to facility report. These procedures were reviewed; procedures for Industrial Therapy Assignments, Physical/Occupational Therapy Services, and Speech Pathology and Audiology were found to lack language and process consistent with the Wellness and Recovery Model. The facility continues to maintain separate operations manuals for Rehabilitation Services, Occupational and Physical Therapy, Speech Therapy, and Vocational Rehabilitation. Vocational Rehabilitation has not yet been integrated into the Rehabilitation Services department, but is under the Education Department according to the most recent organizational chart and report of current practice. A draft of the revised Rehabilitation Services Manual was reviewed and found to contain Wellness and Recovery Model language and philosophy and to include a description of Occupational, Physical, and Speech Therapy, and Vocational Rehabilitation services. However, the Rehabilitation Services manual draft does not currently include specific procedural requirements and/or appendices of assessment tools, instructions, and monitoring tools/instructions for Occupational, Physical, and Speech Therapy, Comprehensive Rehabilitation (POST) assessments, and Vocational Rehabilitation Services as these protocols/tools have not yet been developed. A list of standardized assessment/evaluation tools and corresponding reliability and validity data for possible focused assessments has been initiated and should continue to be developed. Physical, Speech and Vocational Rehabilitation assessments are not consistent with corresponding assessments at the other state hospitals. The Physical/Occupational Therapy Services procedure does not specify a time frame for response to or completion of referrals for

		Physical or Occupational Therapy assessments or direct treatment. The Speech Pathology and Audiology procedure states that consultations for Speech Therapy assessments are to be answered within two weeks of referral, and Speech Therapy treatment should be initiated within seven days of referral. A list of standardized assessments used by the current Speech Therapist was reviewed and appears to be consistent with generally accepted professional standards of care. Upon review of the Comprehensive Assessments for Dysphagia and Aspiration Management, and Physical Therapy, Occupational Therapy, Speech Therapy and Vocational Rehabilitation assessments, it is noted that assessments are brief and based primarily on quantitative findings, with minimal focus on documentation of narrative findings related to qualitative clinical observations and function. None of these assessments were found to contain inclusion of Wellness and Recovery principles/Enhancement Plan requirements related to functional status, individual goals, strengths, motivation, and skills/supports needed to transfer to the next level of care. No consistent protocol, instructions, or monitoring tools for these assessments have been developed or implemented. According to interview and review of the Dysphagia and Aspiration Management procedure, the Comprehensive Assessment for Dysphagia and Aspiration Management is currently administered upon referral generated by the WRPT upon change in status or based on results of screening upon admission. The assessment appears to be interdisciplinary in format, with Dysphagia and Aspiration Management team meetings conducted to assign risk level, complete each comprehensive assessment, and generate recommendations for report to the WRPT. However, risk levels are not consistent with facility-wide key indicator risk levels, and the current system of level assignment requires that all individuals are at a level of risk for dysphagia. The

		current Comprehensive Assessment for Dysphagia and Aspiration Management is appropriate to meet the needs of individuals with dysphagia, but is not comprehensive enough at this time to meet the rehabilitation therapy needs of individuals across functional domains. Currently, there are three interdisciplinary specialized teams for addressing risk factors related to physical rehabilitation, including Falls, Dysphagia, and Rehabilitation Management. The team members have recognized the need to merge these teams and corresponding screening tools and assessments into one process. The comprehensive physical rehabilitation needs of the facility would be appropriately addressed with a team comprised of a Physical, Occupational, and Speech Therapist (POST team), which would collaborate with the WRPT and specific professionals (e.g., Nurse, Dietitian) as clinically necessary and indicated on an individualized basis. The current Dysphagia/Choking/Aspiration screening tool includes a section to identify risk factor indicators (e.g., history of CVA, history of dementia). This screening is an excellent start at developing an integrated Physical Rehabilitation risk screening tool which would serve to generate referrals to the POST team upon admission. According to interview and review of relevant Vocational Rehabilitation procedures and documentation, Vocational Rehabilitation services include: 1) Industrial Therapy Assignments, 2) Vocational Interview Summary, and 3) Vocational Services Discharge Summary form. The Industrial Therapy assignment process includes an application and interview process that is initiated by the individual and/or the WRPT. The WRPT approves/denies the application and if approved, sends the individual to the Industrial Therapy office for a Work Supervisor interview. Those who pass the interview are assigned to a job and hired, and individuals who do not pass the interview are sent to Supported Employment (Horticulture program), with work-based assessment completed. However, according to report, work-based

		assessments are not done in a written format. For individuals with an IEP, a referral for a Vocational Interview summary assessment may be generated. Upon review of this assessment, it is noted that the assessment tool is general and does not include documentation of findings related to functional status, skills/supports needed to transfer to the next level of care, or individual goals, strengths, and motivation. According to facility report, Vocational Services discharge summary assessment is completed for individuals prior to discharge as part of the Department of Rehabilitation and DMH co-op system. On 9/20/07, a teleconference was held among DMH facilities to ensure that this tool was consistent across hospitals. However, it was noted that this tool did not include documentation of findings related to functional status, skills/supports needed to transfer to the next level of care, or individual goals, strengths, and motivation. In addition, there is currently no Department of Rehabilitation counterpart in the community to send these assessments to for follow-through and implementation of recommendations. No assessment tool currently exists to address the Vocational Rehabilitation needs of individuals living at or admitted to PSH who do not have an IEP or are pending imminent discharge. There is not currently a screening tool to be performed at admission or upon change in status to identify individuals who may be in need of Vocational Rehabilitation assessment and/or services. Rehabilitation Services has not yet developed a monitoring tool/process for determining compliance with all areas of Section D.4 of the Enhancement Plan. This should include the facility's measure of compliance based on audit data per cell, as well as a breakdown of data per cell (e.g., for D.4b.i, data would be presented for IA-RTS, POST,

		Vocational Rehabilitation, transfer, and focused assessments). **Compliance:** Partial. **Current recommendations:** 1. Revise and implement Rehabilitation Therapy Manual and organizational chart to reflect changes including departmental integration and restructuring, a description of collaboration among disciplines and therapy teams within the department, and any revised or new Rehabilitation Therapy Services procedures. The Rehabilitation Services Manual should be consistent with manuals at the other state facilities. 2. Revise and implement Integrated Assessment-Rehabilitation Services assessment, instructions, monitoring tool and instructions. 3. Develop and implement a Comprehensive Physical Rehabilitation screening tool to ensure appropriate referral for this service by the WRPT to the POST team. 4. Develop and implement a Comprehensive Physical Rehabilitation assessment as well as instructions that meet the requirements of the Enhancement Plan, incorporate the principles of the Wellness and Recovery model, and are consistent with those of the other state facilities. 5. Develop and implement a Vocational Rehabilitation screening tool to ensure appropriate referral for individuals requiring Vocational Rehabilitation/Industrial Therapy services. 6. Develop and implement a Vocational Rehabilitation assessment as well as instructions that meet the requirements of the Enhancement Plan, incorporate the principles of the Wellness and Recovery model, and are consistent with those of the other state facilities.

D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	**Compliance:** Partial.
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue to revise appropriate policies, procedures and manuals to be aligned with this requirement. **Findings:** See D.4.a for findings regarding this recommendation. **Recommendation 2, June 2007:** Ensure competency of Recreational Therapy staff regarding changes implemented. **Findings:** See D.4.c for findings regarding this recommendation. **Recommendation 3, June 2007:** Develop and implement a system to ensure that referrals generated from the IRTAs are implemented. **Findings:** Referrals are made by the WRPT rather than by Rehabilitation Services therapists. Recommendations for focused assessments should be monitored on corresponding IA-RTS audit tool. **Recommendation 4, June 2007:** Identify, assess, develop and implement proactive interventions for individuals with OT, PT, and/or Speech Therapy needs.

		Findings: See F.4 for findings regarding implementation of Occupational, Physical, and Speech Therapy interventions and supports. **Recommendation 5, June 2007:** Integrate OT, PT, and Speech Therapy assessments and interventions into the individuals' WRPs. **Findings:** See F.4 for findings regarding WRP integration. **Recommendation 6, June 2007:** Continue to assess and develop 24-hour, proactive interventions for individuals at risk for choking and aspiration. **Findings:** See F.4 for findings regarding this recommendation. **Recommendation 7, June 2007:** Develop and implement a monitoring system to ensure that staff are consistently following the dysphagia treatment plans. **Findings:** See F.4 for findings regarding this recommendation. **Recommendation 8, June 2007:** Provide ongoing competency-based training to all team members regarding dysphagia. **Findings:** According to facility report, two out of three new employees received New Employee training related to dysphagia. No data was available

		regarding post-test scores or competency-based measures. **Recommendation 9, June 2007:** Develop and implement a system to track when wheelchairs are modified and that they are regularly assessed to ensure that they continue to meet the individual's needs. **Findings:** See F.4 for findings regarding this recommendation. **Recommendation 10, June 2007:** Develop and implement a system to ensure that adaptive equipment is available and in good working condition. **Findings:** See F.4 for findings regarding this recommendation. **Recommendation 11, June 2007:** Develop and implement a system to ensure timeliness of ordering and receiving adaptive equipment. **Findings:** See F.4 for findings regarding this recommendation. **Recommendation 12, June 2007:** Provide and document training to individuals and staff regarding the appropriate use of adaptive equipment. **Findings:** See F.4 for findings regarding this recommendation.

		Recommendation 13, June 2007: Re-evaluate the adaptive equipment at least annually or in response to the individual's status changes to ensure that it is meeting the individual's needs. **Findings:** See F.4 for findings regarding this recommendation. **Recommendation 14 and 15, June 2007:** • Develop and implement a system to identify, assess, monitor, track, document, and provide ongoing services to individuals who have significant vision and hearing problems and the need for augmentative/adaptive communication devices. • Provide augmentative/adaptive communication devices for individuals with communications issues. **Findings:** Individuals with significant vision and hearing problems are identified upon Nursing 24 Hour and Physician 24 hour admission assessments. According to facility report, there are several individuals (estimated 5-7) who would benefit from low vision assessment and adaptations/ training, but there are no consulting professionals with this expertise available to provide this service. The WRPT refers individuals in need of communication supports for Speech Language assessment and treatment. According to facility report, two individuals (PC and RR) are currently using augmentative/ assistive communication devices (communication booklets). Please see F.4 for additional findings regarding monitoring and tracking of assistive devices.

		Other findings: PSH audit data for June-October 2007 indicates that 90% of admission Integrated Rehabilitation Therapy Assessments were completed within specified time frames (five days for initial evaluations) according to procedure. PSH audit data for June-October 2007 indicates that 66% of transfer Integrated Rehabilitation Therapy Assessments were completed within specified time frames (within seven days of transfer) according to procedure. Upon record review of assessments (transfer and admission) done from June-October 2007, it was noted that 100% contained an Integrated Rehabilitation Therapy Assessment; 93% of assessments were completed within appropriate time frames; 93% were complete, with all sections addressed; 21% were comprehensive; and 14% contained specific measurements of functional abilities. Upon record review of pilot assessments, it was noted that 100% were complete, with all sections addressed; 100% were comprehensive; and 55% contained specific measurements of functional abilities. According to facility report from requested list of individuals who received Occupational Therapy assessments within the six-month review period, 28 Occupational Therapy assessments were completed from May-October 2007. This list was generated by the facility appointment database, and did not specify the date of referral, reason for referral, or whether the assessment was completed with date of completion listed. Record review of Occupational Therapy Assessments revealed that 100% of Occupational Therapy assessments were complete, and 100% addressed functional abilities. Physical/ Occupational Therapy Services procedure regarding assessments did not specify a required timeframe in which assessments are to be

		completed, and thus no finding regarding compliance with timeliness can be made at this time. According to facility report from requested list of individuals who received Physical Therapy assessments within the six-month review period, 43 Physical Therapy assessments were completed from May-October 2007. This list was generated by the facility appointment database, and did not specify the date of referral, reason for referral, or whether the assessment was completed with date of completion listed. Four out of ten records of individuals on the list of Physical Therapy assessments showed no referral for PT, but rather for consultation for equipment without formal assessment requested. Record review of Physical Therapy Assessments revealed that only six out of ten records contained referrals for Physical Therapy assessments, and two of these assessments were not in the record. Of the four assessments present, four were complete and one addressed functional abilities. As discussed above, the Physical/Occupational Therapy Services procedure regarding assessments did not specify a required timeframe in which assessments are to be completed, and thus no finding regarding compliance with timeliness can be made at this time. According to facility report from requested list of individuals who received Speech Therapy assessments within the six-month review period, 36 Speech Therapy assessments were completed from May-October 2007. This list was generated by the facility appointment database, and did not specify the date of referral, reason for referral, or whether the assessment was completed with date of completion listed. Review of Speech Therapy Assessments showed that 100% were complete and 38% addressed functional abilities. Timeliness was unable to be determined because the date of referral was not listed on assessment or database.

		According to facility report from requested list of individuals who received a Comprehensive Assessment for Dysphagia and Aspiration Management within the six-month review period, 31 assessments were completed from May-October 2007. This list did not specify the date of referral, reason for referral, or whether the assessment was completed with date of completion listed. Record review of Comprehensive Assessments for Dysphagia and Aspiration Management revealed that 100% of assessments were complete, 56% were completed within two weeks of referral per procedure, and 90% addressed functional abilities. According to facility report, only two Vocational Rehabilitation Assessments were ordered within the six-month review period. Both assessments were complete but lacked specific measures of functional abilities. **Current recommendations**: 1. Develop and implement monitoring tool(s) and instructions for Physical, Occupational, and Speech Therapy assessments, Vocational Rehabilitation Assessment, and Comprehensive Physical Rehabilitation Assessment (POST) to ensure that all assessments are timely and provide a thorough assessment of functional ability as opposed to a focus on dysfunction and disability. 2. Revise and implement Integrated Assessment- Rehabilitation Therapy Section Monitoring Tool and instructions in collaboration with other state facilities and ensure alignment between monitoring tool, assessment, and EP requirements. 3. Establish inter-rater reliability for all audit/monitoring tools prior to implementation. 4. Ensure that all Rehabilitation Services assessments are accurate and comprehensive as to the individual's functional abilities.

D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	**Findings:** According to PSH Integrated Rehabilitation Assessment audit data for June-October 2007 admissions assessments, 90% addressed functional status (average of Physical Functioning and Social Functioning sections), and 49% identified skills and supports needed to transfer to the next level of care. According to PSH Integrated Rehabilitation Assessment audit data for June-October 2007 transfer assessments, 52% addressed functional status (average of Physical Functioning and Social Functioning sections), and 25% identified skills and supports needed to transfer to the next level of care. The audit data monitoring tool did not appear to provide an accurate measure of whether functional status was addressed. Upon record review of IRTA assessments (admission and transfer) from June-October, it was noted that 21% of assessments identified current functional status and 36% of assessments identified skills and supports needed to facilitate transfer to the next level of care. Upon record review of pilot IA-RTS assessments, it was noted that 100% of assessments identified current functional status and 45% of assessments identified skills and supports needed to facilitate transfer to the next level of care. Review of Occupational Therapy assessments revealed that none of the assessments identified current functional status or skills and supports needed to facilitate transfer to the next level of care. Record review of Physical Therapy assessments showed that of the four assessments available for review, one out of four assessments identified current functional status and none identified skills and supports needed to facilitate transfer to the next level of care. Review of Speech Therapy assessments revealed that 75% of

		assessments identified current functional status and 33% of assessments identified skills and supports needed to facilitate transfer to the next level of care. Upon review of Comprehensive Assessments for Dysphagia and Aspiration Management it was noted that none of the assessments identified current functional status or skills and supports needed to facilitate transfer to the next level of care. Review of Vocational assessments showed that both assessments gave a brief overview of functional status but that neither of the two assessments addressed specific skills and supports needed to facilitate transfer to the next level of care. **Compliance:** Partial. **Current recommendation**: Ensure that all assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care.
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	**Findings:** According to PSH audit data for June-August 2007 (September and October data were not included in a weighted mean, but reported separately) admissions Integrated Rehabilitation Therapy assessments, 54% of assessments identified the individual's life goals, 42% addressed strengths, and 66% identified motivation for engaging in wellness activities. According to PSH audit data for June-October 2007 Integrated Rehabilitation Therapy transfer assessments, 63% of assessments identified the individual's life goals, 47% addressed strengths, and 27% identified motivation for engaging in wellness activities.

		Upon record review of Integrated Rehabilitation Therapy Assessments (admission and transfer) from June-October 2007, it was noted that 100% of assessments identified the individual's life goals, 93% addressed strengths, and 93% identified motivation for engaging in wellness activities. Upon record review of pilot IA-RTS assessments, it was noted that all of the assessments identified the individual's life goals, addressed strengths, and identified motivation for engaging in wellness activities. Review of Occupational Therapy assessments revealed that 86% of assessments identified the individual's life goals, but none addressed strengths or identified motivation for engaging in wellness activities. Record review of Physical Therapy assessments showed that of the four assessments available for review, one out of four assessments identified the individual's life goals and none addressed strengths or motivation for engaging in wellness activities. Review of Speech Therapy assessments revealed that none of the assessments identified the individual's life goals, addressed strengths, or identified motivation for engaging in wellness activities. Upon review of Comprehensive Assessments for Dysphagia and Aspiration Management it was noted that none of the assessments identified the individual's life goals, addressed strengths or identified motivation for engaging in wellness activities. Review of Vocational assessments showed one of two gave a brief overview of the individual's life goals, and both briefly addressed the individual's strengths and life goals.

		Compliance: Partial. **Current recommendation**: Ensure that all assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Develop and implement a system to ensure that Rehabilitation Therapists, including OT, PT and Speech Therapists, are verifiably competent in performing the assessments for which they are responsible. **Findings:** According to facility report: • 16 Rehabilitation Therapists were trained on the use of the newly revised IRTA on May 18, 2007; • 17 Rehabilitation Therapists were trained on May 22, 2007; • 21 Rehabilitation Therapists were trained on May 23, 2007; • One Rehabilitation Therapist was trained on June 1, 2007; • One Rehabilitation Therapist was trained on June 4, 2007; and • One Rehabilitation Therapist was trained on June 6, 2007. This was verified by review of Staff Development attendance sheets. The training did not include competency measures or post-test, and no data was provided regarding how many therapists required training versus received training. According to facility report, 39 Rehabilitation Therapists were re-trained on the use of the newly revised IRTA on July 11, 2007 and four

		were trained on July 30, 2007 based on outcomes of the IRTA audit. This was verified by review of sign-in sheets. No data was provided regarding how many therapists required training versus received training. According to facility report, two Occupational Therapists attended training at Loma Linda University on "Cutting Edge Issues in Dysphagia Management" on June 15, 2007. One Speech Pathologist attended "Dysphagia Practices, Focus of Treatment" training on June 22 through June 24, 2007. No evidence of attendance of these courses was provided. Competency-based trainings for revised Integrated Assessment for Rehabilitation Services and instructions are pending final approval and subsequent implementation of these tools. Competency-based trainings for POST assessments, OT/PT/ST consultations, and Vocational Rehabilitation assessments and instructions are pending development and implementation of these tools. **Recommendation 2, June 2007:** Develop and implement a monitoring system to adequately address the elements of this requirement. **Findings:** This recommendation has not been addressed as a D.4 monitoring tool has not yet been developed. **Compliance:** Partial. **Current recommendation**: Provide competency-based training to all Rehabilitation Services staff regarding changes in departmental procedures, and to appropriate

		staff regarding developed/revised assessment protocols and instructions and monitoring tools/instructions on a discipline-/team-specific basis.
D.4.d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § [IV.D.2], above.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Develop and implement a plan to ensure that all rehabilitation therapy assessments of individuals admitted to PSH prior to June 1, 2006 are reviewed by qualified clinicians and revised as needed. **Findings:** No individuals admitted to PSH prior to June 1, 2006 have received an IA-RTS assessment as this tool has not yet been finalized and implemented. According to facility report, the plan is to administer the IA-RTS to these individuals during the month of each individual's annual assessment in order to complete all D.4.d assessments in the period of one year. **Compliance:** Partial. **Current recommendation**: Ensure that all individuals admitted to PSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section assessment within the next twelve months.

5. Nutrition Assessments		
D.5	Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:	**Methodology:** Interviewed: 1. Tai Kim, Director of Nutrition Services 2. Kitchie Miana, Assistant Director of Nutrition Services 3. Dolores Otto Moreno, Assistant Director of Nutrition Services 4. Grace Ferris, Assistant Director of Nutrition Services Reviewed: 1. DMH Nutrition Care Monitoring Tool and Instructions 2. DMH Nutrition High Risk Referral 3. DMH Nutrition Care Process 4. DMH Nutrition Assessment and instructions 5. DMH Nutrition Update and instructions 6. Professional Dietetics Meeting Minutes from 6/13/07, 7/11/07, 8/8/07, and 9/12/07 7. Quality Improvement Meeting Minutes from 7/11/07 8. Consult/High Risk Monitoring database for May-October 2007 9. List of numbers of overdue/not completed assessments from May-October by month 10. Nutrition Care Monitoring data summary for May-October 2007 (weighted mean of all assessment types) 11. Nutrition Care Monitoring audit data for May-October for each assessment type 12. Lists of individuals who received Nutrition Care Assessment from May-October 2007 for each assessment type 13. Records of the following individuals receiving type a. assessments from May-October 2007: VQ, BMP, RH, DL 14. Records of the following individuals receiving type d. assessments from May-October 2007: JMP, PS, PJS, HS, LHK 15. Records of the following individuals receiving type e. assessments from May-October 2007: JGP, ACP, JH, RCM, TGA, EBW, CB

		16. Records of the following individual receiving type f. assessments from May-October 2007: JAG, IAD, CGW, JM, MAS 17. Records of the following individuals receiving type g. assessments from May-October 2007: JML, DR, SJW, YEH, HCC, RK, NT, CB 18. Records of the following individuals receiving type i. assessments from May-October 2007: AHG, JDK, ARB, JM, DP, MJT, JFP, HLE, JP, GRH, DAP 19. Records of the following individuals receiving type j.i. assessments from May-October 2007: IC, RLB, LLF, RLC, TRF, WL, RB, AAA, RO, EC 20. Records of the following individuals receiving type j.ii. assessments from May-October 2007: BM, JAM, PWW, BM2, BEK, WMP, MH, TCH, GLT, DEA, CDA
D.5.a	For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** 1. Present data regarding quality of nutritional assessments. 2. Continue to monitor this requirement. **Findings:** According to facility report, six individuals were scheduled for type a. assessments between May-October 2007, and six records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for May-October 2007, 33% of assessments were completed on time, 67% had complete subjective findings, 67% had complete objective findings, 50% had correctly formulated nutrition diagnosis, 67% had individualized and measurable goals, and 33% had appropriate recommendations. A review of the records of four individuals requiring type a. assessments from May-October 2007 indicated that 25% of

		assessments were completed on time, 100% had complete subjective findings, 75% had complete objective findings, 75% had correctly formulated nutrition diagnosis, 75% had individualized and measurable goals and 100% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within three days of admission.	Not applicable. PSH does not have a medical-surgical unit.
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within seven days of admission.	Not applicable. PSH does not have a skilled nursing facility unit.
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24 hours, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within seven days of admission.	**Current findings on previous recommendation:** **Recommendations 1-2, June 2007:** 1. Present data regarding quality of nutritional assessments. 2. Continue to monitor this requirement. **Findings:** According to facility report, 47 individuals were scheduled for type d. assessments between May-October 2007, and 47 records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for May-October 2007,

		72% of assessments were completed on time, 87% had complete subjective findings, 82% had complete objective findings, 76% had correctly formulated nutrition diagnosis, 73% had individualized and measurable goals, and 76% had appropriate recommendations. A review of the records of five individuals requiring type d. assessments from May-October 2007 indicated that 60% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 80% had individualized and measurable goals and 80% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within seven days of admission.	**Current findings on previous recommendation:** **Recommendation 1-2, June 2007:** 1. Present data regarding quality of nutritional assessments. 2. Continue to monitor this requirement. **Findings:** According to facility report, 39 individuals were scheduled for type e. assessments between May-October 2007, and 39 records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for May-October 2007, 56% of assessments were completed on time, 84% had complete subjective findings, 89% had complete objective findings, 84% had correctly formulated nutrition diagnosis, 84% had individualized and

		measurable goals, and 64% had appropriate recommendations. A review of the records of seven individuals requiring type e. assessments from May-October 2007 indicated that 43% of assessments were completed on time, 86% had complete subjective findings, 71% had complete objective findings, 71% had correctly formulated nutrition diagnosis, 86% had individualized and measurable goals and 86% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.f	For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.	**Current findings on previous recommendations:** **Recommendation 1-2, June 2007:** 1. Present data regarding quality of nutritional assessments. 2. Continue to monitor this requirement. **Findings:** According to facility report, 45 individuals were scheduled for type f. assessments between May-October 2007, and 45 records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for May-October 2007, 58% of assessments were completed on time, 64% had complete subjective findings, 76% had complete objective findings, 87% had correctly formulated nutrition diagnosis, 75% had individualized and measurable goals, and 64% had appropriate recommendations. A review of the records of five individuals requiring type f.

		assessments from May-October 2007 indicated that 60% of assessments were completed on time, 80% had complete subjective findings, 100% had complete objective findings, 80% had correctly formulated nutrition diagnosis, 80% had individualized and measurable goals and 40% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	**Current findings on previous recommendation:** **Recommendation 1-2, June 2007:** 1. Present data regarding quality of nutritional assessments. 2. Continue to monitor this requirement. **Findings:** According to facility report, 451 individuals were scheduled for type g. assessments between May-October 2007, and 121 records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for May-October 2007, 89% of assessments were completed on time, 85% had complete subjective findings, 84% had complete objective findings, 85% had correctly formulated nutrition diagnosis, 84% had individualized and measurable goals, and 79% had appropriate recommendations. A review of the records of eight individuals requiring type g. assessments from May-October 2007 indicated that 88% of assessments were completed on time, 100% had complete subjective findings, 100% had complete objective findings, 100% had correctly

		formulated nutrition diagnosis, 100% had individualized and measurable goals and 100% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Continue to pursue additional staff for the Nutrition Department. **Findings:** Currently, PSH employs eight dietitians to serve over 1500 individuals and as a result, many assessments are not completed and are not consistently timely. According to facility report, 613 Nutrition Assessments were overdue or not completed as of October 2007. A total of 49 out of 61 records reviewed by this monitor contained a completed Nutrition Assessment. According to the Director of Nutrition Services, dietician salaries are 50-60% below what is considered competitive. **Recommendations 2 and 3, June 2007:** 2. Present data regarding quality of nutritional assessments. 3. Continue to monitor this requirement. **Findings:** Upon record review of all assessment types for all assessments completed (total of 49) from May-October, it is noted that an average (weighted mean) of 92% of Nutrition Care assessments had evidence of

		a correctly assigned NST level. Facility database for all assessment types for May-October indicated that an average (weighted mean) of 91% of assessments audited from May-October had evidence of a correctly assigned NST level. **Compliance:** Partial. **Current recommendations**: 1. Recruit and retain additional staff dietitians for Nutrition Department. 2. Continue current practice.
D.5.i	The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.	**Current findings on previous recommendation:** **Recommendations 1-2, June 2007:** 1. Separate and report items in alignment with the EP. 2. Continue to monitor this requirement. **Findings:** According to facility report, 718 individuals were scheduled for type i. assessments between May-October 2007, and 145 records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for May-October 2007, 26% of assessments were completed on time, 97% had complete subjective findings, 92% had complete objective findings, 85% had correctly formulated nutrition diagnosis, 83% had individualized and measurable goals, and 100% had appropriate recommendations. A review of the records of 11 individuals requiring type i. assessments from May-October 2007 indicated that 64% of assessments were

		completed and 36% of assessments were completed on time. Upon review of the completed assessments, it is noted that 100% had complete subjective findings, 100% had complete objective findings, 100% had correctly formulated nutrition diagnosis, 75% had individualized and measurable goals, and 75% had appropriate recommendations. **Compliance:** Partial. **Current recommendations**: 1. Recruit and retain additional staff dietitians for Nutrition Department. 2. Continue current practice.
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Develop and implement a consistent system for Nutrition consults. **Findings:** The Nutrition High Risk-Referral Form has been revised and implemented. According to facility report, 164 out of 216 consultation/high risk referrals (76%) were completed between May-October 2007. **Recommendation 2, June 2007:** Break out data for different timeframes for reassessments. **Findings:** Currently, all categories for change in condition are reported separately; this is verified by review of monitoring data tables for 24 hour, seven-day, and 14-day referrals.

		Recommendation 3, June 2007: Continue to monitor this requirement. **Findings:** According to facility report, 26 individuals were scheduled for type j.i. 24 hour referral assessments between May-October 2007, and four records were audited using the Nutrition Care Monitoring Tool. A total of 186 individuals had type j.i. seven-day referral assessments between May-October, and 42 records were audited using the Nutrition Care Monitoring Tool. It is reported that four individuals had type j.i. 14-day referrals between May-October, and four records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for May-October 2007, for j.i. 24 hour referrals, 100% of assessments were completed on time, 100% had complete subjective findings, 100% had complete pertinent objective findings, 100% had correctly formulated nutrition diagnosis, 75% had individualized and measurable goals, and 85% had appropriate recommendations, and 100% had appropriate recommendations. According to Nutrition Assessment audit data for May-October 2007, for j.i. seven-day referrals, 64% of assessments were completed on time, 88% had complete subjective findings, 84% had complete pertinent objective findings, 84% had correctly formulated nutrition diagnosis, 81% had individualized and measurable goals, and 63% had appropriate recommendations. According to Nutrition Assessment audit data for May-October 2007, for j.i. 14-day referrals, 100% of assessments were completed on time, 100% had complete subjective findings, 25% had complete pertinent objective findings, 25% had correctly formulated nutrition diagnosis,

		50% had individualized and measurable goals, and 50% had appropriate recommendations. A review of the records of 10 individuals receiving type j.i. assessments (weighted mean of sample of the three j.i. sub-types) from May-October 2007 indicated that 90% of assessments were completed and 60% of assessments were completed on time. Of the completed Nutrition Assessments, 89% had complete subjective findings, 100% had complete pertinent objective findings, 89% had correctly formulated nutrition diagnosis, 78% had individualized and measurable goals and 100% had appropriate recommendations. **Compliance:** Partial. **Current recommendations**: 1. Recruit and retain additional staff dietitians for Nutrition Department. 2. Continue current practice.
D.5.j.ii	Every individual will be assessed annually.	**Current findings on previous recommendation:** **Recommendations 1-2, June 2007:** 1. Present data regarding quality of nutritional assessments. 2. Continue to monitor this requirement. **Findings:** According to facility report, 529 individuals were scheduled for type j.ii assessments between May-October 2007, and 107 records were audited using the Nutrition Care Monitoring Tool. According to Nutrition Assessment audit data for May-October 2007, 26% of assessments were completed on time, 97% had complete

		subjective findings, 90% had complete pertinent objective findings, 97% had correctly formulated nutrition diagnosis, 81% had individualized and measurable goals, and 87% had appropriate recommendations. A review of the records of 11 individuals requiring type j.ii assessments from May-October 2007 indicated that 36% of assessments were completed on time, and 64% were completed. Of the completed assessments, 86% had complete subjective findings, 86% had complete pertinent objective findings, 71% had correctly formulated nutrition diagnosis, 71% had individualized and measurable goals and 86% had appropriate recommendations. **Compliance:** Partial. **Current recommendations:** 1. Recruit and retain additional staff dietitians for Nutrition Department. 2. Continue current practice.

6. Social History Assessments		
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	**Methodology:** Interviewed: 1. Veronica Kaufman, LCSW, Chief of Social Work 2. Anthony Ortega, LCSW, Social Work Assessment Team Leader 3. Craig Tucker, LCSW, Social Work Family Therapy Team Leader 4. Rachel Strydom, LCSW, Social Work Discharge Team Leader 5. Kitasha Jones, LCSW, Social Work Admission Unit Supervisor 6. Sjoekje Sasebone, LCSW Reviewed: 1. Charts of 20 individuals: BED, BRF, DRH, EB, ER, GC, JFN, JL, JSR, LEM, MB, MWD, PMB, RP, SAA, SB, SD, TJE, WVF, and YB 2. DMH Integrated Assessment: Social Work Section 3. DMH Integrated Assessment: Social Work Section Instructions 4. DMH 30-Day Psychosocial Assessment 5. DMH 30-Day Psychosocial Assessment Instructions 6. DMH Annual Psychosocial Assessment 7. DMH Annual Psychosocial Assessment Instructions 8. PSH Psychosocial Assessment Update 9. DMH Psychosocial Assessment Update Instructions 10. Social Work Assessment Monitoring form Instruction Sheet 11. PSH Progress Report Data Observed: 1. WRPC (Program VIII, unit 25) for BDM 2. WRPC (Program IV, unit 34) for DLG 3. WRPC (Program VI, unit EB-02) for AV 4. WRPC for JL 5. PSR Mall group: Smoking Cessation: You Can Quit 6. PSR Mall group: 64 Ways to Non-Violence (Program III, unit 31)

D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Current findings on previous recommendations:** **Recommendations 1-4, June 2007:** • Consistently implement the five-day Integrated Psychosocial Assessments, and the 30-day Social history assessments. • Develop, finalize and implement statewide annual social history evaluations. • Align monitoring tools with the EP. • Ensure that all social history assessments are conducted in a timely manner. **Findings:** According to Veronica Kaufman, an Integrated Social Work Assessment is due within five days of an individual's admission, and a 30-day Psychosocial Assessment is due within 30 calendar days after admission. The Integrated Social Work Assessment and the 30-Day Psychosocial Assessment tools were revised to align with the EP and were implemented on November 1, 2007. The SW monitoring tools now include an item (item #11, "*The assessment contributes to clinical decision making, discharge planning and aftercare services*") to evaluate the quality of its assessments. PSH used items #1, #2, and #3 from the DMH Social History Assessment Audit Form (5-Day) to evaluate the implementation of the five-day Integrated Psychosocial Assessments to address this recommendation, reporting 50%, 81%, and 66% compliance respectively. The table below with its monitoring indicators showing the number of five-day Social History Assessments due (N), the number of five-day assessments audited (n) and the percentage of compliance obtained (%C), is a summary of the facility's data. *Is, to the extent reasonably possibly accurate (#1), current/timely*

(#2), and comprehensive (#3).

	5/07	6/07	7/07	8/07	9/07	10/07	Mean
N	107	90	140	89	109	121	
n	33	22	31	19	106	108	
%S	30	24	22	21	97	89	
%C, #1	100	27	29	53	41	69	50
%C, #2	85	68	71	84	85	81	81
%C, #3	52	59	52	63	74	64	66

PSH used items #1, #2, and #3 from the DMH Social History Assessment Audit Form (30-Day) to evaluate the implementation of the 30-day Psychosocial Assessments to address this recommendation, reporting 35%, 42%, and 29% respectively. The table below with its monitoring indicators showing the number of 30-day Social History Assessments due (N), the number of 30-day assessments audited (n) and the percentage of compliance obtained (%C), is a summary of the facility's data.

Is, to the extent reasonably possibly accurate (#1), current/timely (#2), and comprehensive (#3)

	5/07	6/07	7/07	8/07	9/07	10/07	Mean
N	92	107	90	140	89	101	
n	45	24	30	30	24	33	
%S	48	22	33	21	27	33	
%C, #1	9	37	16	26	17	72	35
%C, #2	20	50	16	10	17	79	42
%C, #3	0	25	13	20	16	70	29

According to Veronica Kaufman, Chief of Social Work, the SW department conducts monthly audits to monitor compliance and

		provides feedback at social work meetings. The Chief of Social Work also indicated that the delay in completing the 30-day assessments was due to the 60-day turn-around time limitation for new admissions, it is nearly impossible to complete all assessments in a timely manner, due to the large number of assessments each social worker is expected to complete. However, she sees the situation improving with an additional admission unit to be opened soon, since the staff will have more time to complete the assessments. Furthermore, the Social Service department has assigned Social Work teams specialized in assessments to assist unit Social Workers in completing the 30-Day Psychosocial Assessment due each month. This monitor reviewed 17 charts (BED, SB, PMB, GC, MWD, DA, EB, WVF, JL, BRF, YB, JFN, TJE, SD, SAA, DRH, and RP) containing the SW five-day assessments. Fourteen of the assessments (BED, SB, PMB, GC, MWD, DA, BRF, YB, JFN, TJE, SD, SAA, DRH, and EB) were present and conducted in a timely manner, two of them (WVF and RP) were present but not timely, and one of them (JL) was not present in the chart. This monitor also reviewed 12 charts (LEM, ER, GC, JL, MB, JSR, SAA, YB, TJE, JFN, SD, and BRF) containing 30-day Social History assessments. Five of them were present and timely (LEM, ER, GC, SAA, and MB) and three of them (YB, JSR, and JL) were present but untimely, and four of them (TJE, JFN, SD, and BRF) were not present in the charts. **Compliance:** Partial. **Current recommendations**: Ensure that the five-day and 30-day Social history assessments are timely, accurate, and comprehensive.

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<tr><td>D.6.b</td><td>Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;</td><td>

Current findings on previous recommendations:

Recommendations 1-3, June 2007:

- Ensure that Social History assessments contain all relevant information.
- Ensure that social workers identify and address the inconsistencies in current assessments.
- Monitor factual inconsistencies in social histories and revise to correct the inconsistencies.

Findings:

PSH used the items #4, #5, and #6 from the DMH Social History Assessment Audit Form (30-Day) to address this recommendation, reporting 34%, 32%, and 31% compliance respectively. The table below with its monitoring indicators showing the number of 30-Day Assessments due for the month (N), the number of 30-Day Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Expressly identifies factual inconsistencies among sources (#4).
Resolves or attempts to resolve inconsistencies (#5).
Explains the rationale for the resolution offered (#6).

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<tr><td>%S</td><td>48</td><td>22</td><td>33</td><td>22</td><td>27</td><td>33</td><td></td></tr>
<tr><td>%C, #4</td><td>13</td><td>37</td><td>17</td><td>32</td><td>13</td><td>57</td><td>34</td></tr>
<tr><td>%C, #5</td><td>9</td><td>33</td><td>17</td><td>26</td><td>13</td><td>54</td><td>32</td></tr>
<tr><td>%C, #6</td><td>4</td><td>33</td><td>17</td><td>26</td><td>8</td><td>54</td><td>31</td></tr>
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According to Veronica Kaufman, Chief of Social Work, training was

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		conducted in the last few months with Social Workers on proper ways to address factual inconsistencies. All three indicators in the table above have shown significant improvement for the month of October 2007. This monitor reviewed eight charts (LEM, ER, GC, JSR, MB, BRF, TJE, and SD). Three of them (LEM, ER, and GC) addressed the factual inconsistencies, two of them (JSR and MB) did not address the factual inconsistencies, and three of them (BRF, TJE, and SD) did not have the assessments in the charts. Four of them (JSR, ER, GC, and MB) also were not comprehensive. **Compliance:** Partial. **Current recommendations**: 1. Ensure that Social History assessments contain all relevant information. 2. Ensure that social workers identify and address the inconsistencies in current assessments. 3. Monitor factual inconsistencies in social histories and revise to correct the inconsistencies.
D.6.c	Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Ensure that all social history integrated assessments are completed in a timely fashion and made available to the individual's WRPT before the seven-day WRPC. • Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.

Findings:
PSH used item #7 from the DMH Social History Assessment Audit Form (5-Day) to address this recommendation, reporting 61% compliance. The table below with its monitoring indicator showing the number of 7-Day Integrated Assessments due for the month (N), the number of 7-Day Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Is included in the seven-day integrated assessment (#7).

	6/07	7/07	8/07	9/07	10/07	Mean
N	90	140	89	109	121	
n	22	31	19	106	108	
%S	24	22	21	97	89	
%C, #7	59	48	58	62	64	61

PSH also used the items #8 from the DMH Social History Assessment Audit Form (30-Day) to address this recommendation, reporting 26% compliance. The table below with its monitoring indicator showing the number of 30-Day Assessments due for the month (N), the number of 30-Day Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Fully documented by the 30th day of an individual's admission (#8).

	6/07	7/07	8/07	9/07	10/07	Mean
N	107	90	140	89	101	
n	24	30	31	24	33	
%S	22	33	22	27	33	
%C, #8	25	10	19	14	48	26

This monitor reviewed eight SW Integrated Assessments (BED, SB,

		PMB, EB, MWD, GC, WVF, and RP). Four of them (BED, SB, PMB, and EP) met criteria, two of them did not update the information (MWD and GC), and two of them (WVF and RP) were not present in the chart. This monitor also reviewed eight 30-day Social History Assessments (LEM, JSR, ER, GC, MB, BRF, JFN, and SD). Five of them (KEM, JSR, ER, GC, and MB) did not include updated information, and three (BRF, JFN, and SD) were not in the chart. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all social history integrated assessments are completed in a timely fashion and made available to the individual's WRPT before the seven-day WRPC. 2. Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT. **Findings:** PSH used item #9 and #10 from the 30-Day Psychosocial Assessment Audit Form to address this recommendation, reporting 34% compliance for each of the items. The table below with its monitoring indicators showing the number of 30-Day Psychosocial Assessments due each month (N), the number of 30-day Psychosocial Assessments audited (n), and the percentage of compliance obtained (%C) is a summary of

the facility's data.

Reliably informs the individual's interdisciplinary team about the individual's relevant social factors (#9), and educational status (#10).

	6/07	7/07	8/07	9/07	10/07	Mean
N	107	90	140	89	101	
n	24	30	31	24	33	
%S	22	33	22	27	33	
%C, #9	37	17	29	13	58	34
%C, #10	25	16	35	17	58	34

This monitor reviewed five 30-day Psychosocial Assessments (JSR, ER, GC, LEM, and MB). Two of them (JSR and ER) addressed the individuals' educational status and social factors, one (GC) did not address the individual's social factors, one (LEM) did not address the individual's educational status, and one (MB) did not address the individual's educational status or the social factors.

Compliance:
Partial.

Current recommendations:
Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT.

7. Court Assessments		
		Methodology: Interviewed: Ai-Li Aris, MD, Chair, Forensic Review Panel (FRP) Reviewed: 1. Charts of seven individuals who were admitted under PC 1026 (ATR, LFC, EK, JGJ, VFR, FW and RAD) 2. Charts of six individuals who were admitted under PC 1370 (CH, KB, RLB, OA, JB and YM) 3. DMH Manual for the Preparation of PC 1026 and PC 1370 Court Reports 4. Outline of training provided by members of the FRP to all clinicians 5. Minutes of the FRP 6. Examples of e-mails containing feedback from FRP to WRPTs 7. Court Report PC 1026 Audit Tool 8. Court Report PC 1026 summary data (May to October 2007) 9. Court Report PC 1370 Audit Tool 10. Court Report PC 1370 summary data (May to October 2007)
D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	**Compliance:** Substantial.
D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing	**Current findings on previous recommendations:** **Recommendation 1, June 2007:**

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<td>factor in the commission of the crime (i.e., instant offense);</td>
<td>The FRP should continue to review all PC 1026 reports and provide feedback to the teams, with follow-up, to ensure compliance with plan requirements prior to court submission.

Findings:
PSH has implemented this recommendation. The FRP has reviewed 100% of all PC 1026 reports that were completed during this review period. The following table outlines the number of reports that were reviewed by the panel:

<table>
<tr><th>Month</th><th>Reports Reviewed</th></tr>
<tr><td>May</td><td>55</td></tr>
<tr><td>June</td><td>111</td></tr>
<tr><td>July</td><td>88</td></tr>
<tr><td>August</td><td>70</td></tr>
<tr><td>September</td><td>57</td></tr>
<tr><td>October</td><td>94</td></tr>
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The panel has also provided appropriate feedback to the WRPTs to ensure compliance with EP requirements. The following graph illustrates an upward trend in the overall compliance rate with EP requirements in this section based on the facility's internal monitoring data.</td>
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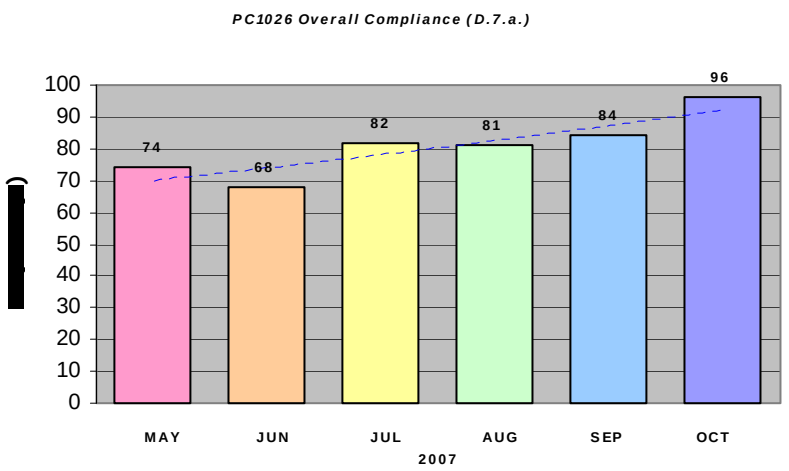


Recommendation 2, June 2007:
Continue to monitor using adequate sample sizes.

Findings:
Using the Court Report PC 1026 Audit Tool, PSH reviewed a 100% sample during this review period (May to October 2007). The mean compliance rate with this requirement was 95%. The mean compliance rates for the requirements in D7.a.ii through D7.a.xi are reported for each corresponding cell below.

Other findings:
PSH provided adequate analysis of data, including areas of lower compliance. To address these areas, the Chair of the FRP provided training in Forensic Report Writing for PC 1026 in September 2007.

The DMH, with the assistance of PSH's Chair of the FRP, has developed and finalized a Manual for the Preparation of PC 1026 and PC 1370 Court Reports. The Manual includes a clear outline of operational steps required for proper implementation of all EP requirements in the area

		of Court Assessments. This monitor reviewed the charts of seven individuals who were admitted under PC 1026 (ATR, LFC, EK, JGJ, VFR, FW and RAD). This review showed compliance in three charts (LFC, EK and JGJ), partial compliance in two (FW and RAD) and non-compliance in two (VFR and ATR). **Current recommendations:** 1. Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements. 2. Ensure that 1026 reports are written in a consistent format. 3. Continue to monitor this requirement based on a 100% sample.
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above. **Findings:** PSH reported a mean compliance rate of 83% with this requirement. **Other findings:** Reviewing seven charts, this monitor found compliance in six (ATR, LFC, EK, VFR, FW and RAD) and partial compliance in one (JGJ). The facility's analysis noted a trend of improvement in addressing verbal/physical aggressive acts and property damage in the past year, including past acts of dangerous/criminal behavior. With feedback from the FRP, the PSH has improved its compliance rate to >90% (October 2007).

		Current recommendations: Same as above.
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above. **Findings:** The facility's mean compliance rate was 81%. PSH reported very slow but steady improvement in addressing the individual's understanding of the potential for danger and precursors of dangerous/criminal behavior, including the instant offense. As a result of the training provided in September 2007, the facility achieved >90% compliance in October 2007. **Other findings:** Reviews by this monitor showed compliance in six charts (ATR, LFC, EK, JGJ, VFR and RAD) and non-compliance in one (FW). **Current recommendations**: Same as above.
D.7.a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above. **Findings:** PSH reported the following mean compliance rates:

		1. *Acceptance of mental illness* 93% 2. *Understanding of the need for treatment* 95% 3. *Understanding of the need to adhere to treatment* 85% Data analysis by PSH addressed the lower compliance regarding the individual's understanding of the need to adhere to treatment. Following the training of September 2007, the compliance rate for this sub-item rose to >90% in October 2007. **Other findings:** This monitor's review of seven charts showed compliance in five (ATR, LFC, EK, JGJ and RAD), partial compliance in one (FW) and non-compliance in one (VFR) **Current recommendations**: Same as above.
D.7.a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above. **Findings:** The facility's mean compliance rate was 90%. PSH addressed this item in the training of September 2007 and the compliance rate improved to >90% in October 2007. **Other findings:** This monitor found compliance in two charts (EK and RAD), partial compliance in four (ATR, LFC, JGJ and FW) and non-compliance in one (VFR).

		Current recommendations: Same as above.
D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above. **Findings:** PSH reported a mean compliance rate of 88%. The facility's data showed a significant increase of compliance in October 2007 (96%). **Other findings:** This requirement was applicable in five of the charts reviewed by this monitor. The review showed compliance in three (LFC, JGJ and VFR) and partial compliance in two (ATR and FW). **Current recommendations**: Same as above.
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above. **Findings:** PSH reported a mean compliance rate of 95%. **Other findings:** This monitor found compliance in all the charts reviewed (ATR, LFC, EK, VFR and RAD). This requirement did not apply to the charts of JGJ and FW).

		Current recommendations: Same as above.
D.7.a.viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above. **Findings:** The facility reported a mean compliance rate of 71%. The facility's data showed significant and steady improvement in compliance since August 2007. **Other findings:** This monitor found compliance in five charts (ATR, EK, VFR, FW and RAD) and partial compliance in two (LFC and JGJ). **Current recommendations**: Same as above.
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above. **Findings:** PSH reported a mean compliance rate of 40% with this requirement. The facility's data showed very gradual improvement in compliance during this review period (up to 77% in October 2007). The facility reported that the primary comment received from the WRPTs was that

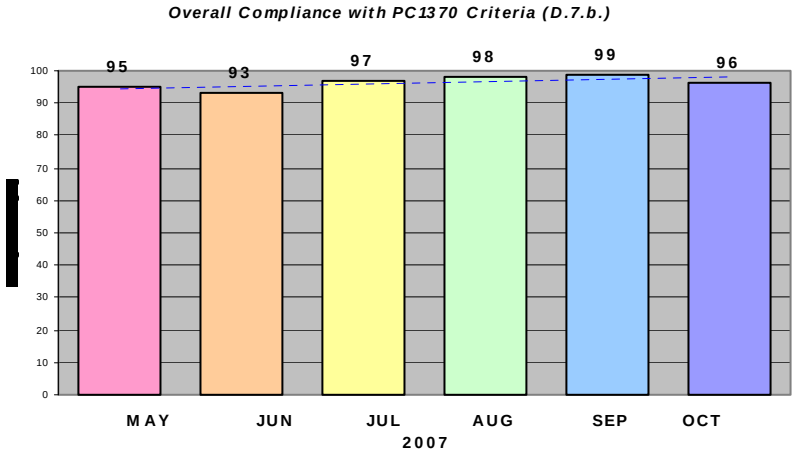
		precautions were "implied" throughout the report. The facility addressed this issue in the training provided in September 2007. **Other findings:** This monitor found compliance in one chart (EK), partial compliance in four (ATR, LFC, JGJ and RAD) and non-compliance in two (VFR and FW). **Current recommendations:** Same as above.
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	**Compliance:** Substantial.
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as D.7.a.i (as applicable to PC 1370).

Findings:

The FRC has reviewed 100% of the reports that were completed during this review period (May to October 2007). The following table outlines the number of reports reviewed.

Month	Reports Reviewed
May	71
June	173
July	91
August	136
September	76
October	132

During this review period, the FRP has provided feedback to the WRPTs to ensure compliance with EP requirements. The following graph illustrates overall compliance rates that exceeded 90% regarding all requirements of this section.



Using the Court Report PC 1370 Audit Tool, the facility reported a

		mean compliance rate of 100% with this requirement. The mean compliance rates for requirements in D7.b.ii through D7.b.iv are reported in each corresponding cell below. **Other findings:** This monitor reviewed six charts of individuals admitted under PC 1370 (CH, KB, RLB, OA, JB and YM). The review showed compliance in all charts. **Current recommendations**: Same as D.7.a.i (as applicable to PC 1370).
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above. **Findings:** PSH reported a mean compliance rate of 98%. **Other findings:** This monitor found compliance in all charts reviewed (CH, KB, RLB, OA, JB and YM). **Current recommendations**: Same as above.
D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above.

		Findings: PSH reported the following mean compliance rates: 1. *Description of any progress or lack of progress* 100% 2. *Individual's response to treatment* 99% 3. *Current relevant mental status* 99% 4. *Reasoning to support the recommendations* 93% **Other findings:** This monitor found compliance in three charts (RLB, JB and YM) and partial compliance in three (CH, KB and OA). **Current recommendations**: Same as above.
D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above. **Findings:** The facility's mean compliance rate was 88%. The data showed steady improvement in compliance (May to September 2007). **Other findings:** This monitor found compliance in six charts (CH, RLB, OA, JB and YM) and partial compliance in one (KB). **Current recommendations**: Same as above.

D.7.c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction.	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** The FRP should continue to review all PC 1026 reports and provide feedback to the teams, with follow-up, to ensure compliance with plan requirements prior to court submission. **Findings:** As mentioned earlier, PSH has implemented this recommendation. **Recommendation 2, June 2007:** The Chair of the FRP should have supervisory responsibilities and administrative support to ensure coordination of the FRP process, tracking of the status of all PC 1370 and 1026 reports, prioritization of reports for review by the FRP, keeping minutes of the FRP meetings and provision of feedback to psychiatrists (and other clinicians) and follow-up corrective actions. These essential enhancements would ensure that a full array of forensic services that meet generally accepted professional standards are provided in the California DMH state hospitals. **Findings:** PSH has yet to implement this recommendation. **Compliance:** Substantial. **Current recommendations**: The Chair of the FRP should have supervisory responsibilities and administrative support to ensure coordination of the FRP process, tracking of the status of all PC 1370 and 1026 reports, prioritization of reports for review by the FRP, keeping minutes of the FRP meetings and provision of feedback to psychiatrists (and other clinicians) and

		follow-up corrective actions. These essential enhancements would ensure that a full array of forensic services that meet generally accepted professional standards are provided in the California DMH State Hospitals.
D.7.c.i	The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue current practice. **Findings:** PSH has maintained current practice. **Compliance:** Substantial. **Current recommendations**: Continue current practice.

E. Discharge Planning and Community Integration		
		Summary of Progress: 1. PSH has finalized and implemented the Discharge Planning and Community Integration Monitoring Form. 2. The facility has developed a WRP training module which includes information on integrating discharge planning into the WRP and Mall services. 3. PSH has developed lesson plans for WRP training on discharge planning and community integration. 4. PSH has developed and implemented the Family Therapy Survey Tools, one to be completed by the family, and the other by the individuals.
E	Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.	**Methodology:** <u>Interviewed</u>: 1. Individuals TA, PS, LEF and MH 2. Veronica Kaufman, LCSW, Chief of Social Work 3. Anthony Ortega, LCSW, Social Work Assessment Team Leader 4. Craig Tucker, LCSW, Social Work Family Therapy Team Leader 5. Rachel Strydom, LCSW, Social Work Discharge Team Leader 6. Kitasha Jones, LCSW, Social Work Admission Unit Supervisor 7. Sjoekje Sasebone, LCSW <u>Reviewed</u>: 1. Chart of 25 individuals: AH, AS, BA, BK, CG, CH, GG, GNG, HD, HHD, JC, JL, JM, JO, JS, KH, ME, MF, MG, PAB, RA, RJ, RS, SL, and WML 2. DMH 30-day Psychosocial Assessment 3. Social Work Family Therapy Initial Screening Assessments 4. 30-Day DMH Discharge Planning and Community Integration Auditing Form Instructions

		5. PSH Discharge Tracking Form 6. PSH Discharge Tracking Form Instructions 7. PSH WRP Discharge Planning and Community Integration Auditing Form 8. DMH Discharge Planning and Community Integration Auditing Form Instructions 9. AD #1.00, Written Plan for Professional Services 10. AD #15.42, Wellness and Recovery Plan <u>Observed</u>: 1. WRPC (Program VIII, unit 25) for BDM 2. WRPC (Program IV, unit 34) for DLG 3. WRPC (Program VI, unit EB-02) for AV 4. WRPC for JL 5. PSR Mall group: Smoking Cessation: You Can Quit 6. PSR Mall group: 64 Ways to Non-Violence (Program III, unit 31)
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process. **Findings:** PSH has implemented the newly approved audit tool (October 2007). According to Veronica Kaufman, Chief of Social Work, awareness and training/education has been ongoing with staff (September 19 and 20, 2007) to ensure that they understand what and how assessments and services are related to an individual's discharge process from the time of admission. The Chief of Social Work pointed to the documentation in Section 1.4 of the DMH WRP Manual that discusses the need for regular attention to the discharge process and the importance on involving the individual in his/her discharge planning at all WRPCs.

		This monitor's review of the assessment tools showed that the revised tools are aligned with the EP. Many of these tools include sections that prompt social workers to address discharge matters, including Section 6 of the Psychosocial Assessment (Discharge Planning and Community Integration), Section 17 of the 30-Day Psychosocial Assessment (Discharge Planning and Community Integration), Section 18 (Strengths and Barriers with regard to Discharge Planning and Community Integration), and the Summary section (Include implications of the assessment for rehabilitation activities and discharge planning). **Recommendations 2-3, June 2007:** • Involve the individual in the discharge process through discussion of discharge criteria and how to meet them (e.g. by attending relevant PSR mall groups, individual therapy and by practicing newly acquired skills in the therapeutic milieu, as needed). • Social workers must review discharge status with the WRPT and the individual at all scheduled WRPCs involving the individual. **Findings:** This monitor reviewed eight charts (RA, PAB, WLM, MG, AS, HD, BK, and CH). Two of them (RA and PAB) had documentation to indicate that the team involved the individual and/or discussed discharge matters with the individual. The remaining six (WLM, MG, AS, HD, BK, and CH) did not. This monitor attended four WRPCs (DLG, BDM, AV, and JL). Unfortunately, this monitor was unable to observe the full team process because one individual (new admit) was in five-point restraints and was agitated (spitting and screaming) when the team attempted a bedside conference, two of them refused to attend their scheduled conferences, and the other did not consent (per the staff) to the participation of the monitor and the PSH staff accompanying the

		monitor at the conference (this monitor learned that the individual refused to attend the conference even after the monitor and the other non-treating staff agreed to excuse themselves from the conference). This monitor did observe the team process without the individuals present. All teams functioned in an interdisciplinary manner. Some of them used the team process guide to ensure that the process was properly conducted. However, barriers to discharge matters were not discussed in any of the team meetings (the Social Work team member was not present in one team meeting). **Recommendation 4, June 2007:** Social Work should coordinate discharge planning activities with CONREP. **Findings:** According to Veronica Kaufman, visits are scheduled with CONREP on a regular basis, at least once every six months. Social workers communicate with CONREP via email and telephone. **Compliance:** Partial. **Current recommendations:** 1. Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process. 2. Involve the individual in the discharge process through discussion of discharge criteria and how to meet them (e.g. by attending relevant PSR mall groups, individual therapy and by practicing newly acquired skills in the therapeutic milieu, as needed). 3. Social workers must review discharge status with the WRPT and the individual at all scheduled WRPCs involving the individual.

E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	**Current findings on previous recommendations:** **Recommendations 1-3, June 2007:** • Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. • The individual's life goals should be linked to one or more focus/foci of hospitalization, with associated objectives and interventions. • Ensure that the individual's current WRP satisfies the necessary conditions to successfully meet discharge criteria. **Findings:** PSH audited 22 WRPCs using item #1 (*those factors that likely would foster successful discharge, including the individual's strengths, preferences and personal life goals*) from the DMH WRP Discharge Planning and Community Integration Auditing Form, to address this recommendation, reporting 23% compliance. This monitor reviewed eight charts (BK, CH, RA, GG, JM, JS, AH, and SL). None of the WRPs found in the chart included the individual's strengths/preferences in all active interventions for use by providers involved in individual/Mall groups/enrichment services. Life goals of individuals receive scant attention from WRPTs. This monitor reviewed seven charts (JO, KH, JM, JS, MF, JC, and SL). Only two of them (JO and KH) had developed objectives and interventions using the individual's life goals, whereas the remaining five (JM, JS, MF, JC, and SL) did not. Analysis of the data from the "Discharge Planning and Community Integration" section show that very few WRPs satisfied the necessary conditions for an individual to successfully meet his/her discharge criteria with maximum benefits in a timely manner.

		Compliance: Partial. **Current recommendations**: 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to one or more focus/foci of hospitalization, with associated objectives and interventions. 3. Ensure that the individual's current WRP satisfies the necessary conditions to successfully meet discharge criteria.
E.1.b	the individual's level of psychosocial functioning;	**Current findings on previous recommendation:** **Recommendations 1-3, June 2007:** • Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. • Use the DMH WRP Manual in developing and updating the case formulation. • Ensure that team members are aware of and trained in elements to consider in updating GAF scores. **Findings:** PSH audited 22 WRPCs using item #2 (*the individual's level of psychosocial functioning*) from the DMH WRP Discharge Planning & Community Integration Auditing Form, to address this recommendation, reporting 27% compliance. This monitor reviewed ten charts. Nine of the WRPs in these charts (RA, BK, CH, BA, CG, JM, HD, JS, and MF) included the psychosocial functioning of the individual in the present status section, and one of

		them (RS) did not. The difference in the compliance rates reported by PSH and obtained by this monitor may be due to different modes of audits conducted. PSH used WRPT data to address this recommendation, whereas this monitor used data from WRP audits, as called for in this recommendation. Furthermore, PSH's data were derived from WRPCs in September 2007, whereas the monitor's chart audits were spread over the last six months. In the June 2007 report, the finding for this recommendation indicated that team members might have been confused about updating GAF scores due to the "Current" and "Quarterly" statements in the AXIS 5 section of the WRP, thereby not updating GAF scores during the monthly conferences. The team members interviewed by this monitor indicated that they now update GAF scores whenever there is change in the individual's functioning irrespective of the WRP schedule. The psychology and social work team members interviewed by this monitor knew the elements to be considered when addressing GAF scores. This monitor reviewed six charts (JF, ME, HHD, ES, JH, and RD). There was a close match between the GAF scores and the information found in the WRP case formulations in most of them, for example small improvements in HHD's functioning resulted in a small change in his GAF scores (changed from a score of 40 the last quarter to 48 this quarter). However, RJ's GAF score was unchanged (WRP, 10/9/2007) even though the documentation in his present status section showed he had strong improvements, among others a) reduction in inappropriate behaviors, b) no seclusion or restraint in this quarter, and c) decreased verbal altercations. On the other hand, ME's GAF score was changed from 65 (previous quarter) to 40 (current), but the documentation in the present status section (WRP, 9/11/2007) if anything, showed no or

		slight improvement from the previous WRP. WRPTs should pay close attention to objective data between conferences when making GAF decisions. The teams should also ensure that the documentation in the present status section is compatible with the GAF scores. **Compliance:** Partial. **Current recommendations:** 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. 2. Ensure that team members are aware of and trained in elements to consider in updating GAF scores.
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	**Current findings on previous recommendations:** **Recommendations 1 and 4, June 2007:** • Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. • Discuss with the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge. **Findings:** PSH audited 22 WRPCs using item #3 (*Any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised I previously unsuccessful placements*) from the DMH WRP Discharge Planning and Community Integration Auditing Form, reporting 22% compliance. This monitor attended four WRPCs (EG, BDM, AV, and JL). Discharge matters were not discussed during the case review in any of the

		conferences. In addition, none of the five charts reviewed by this monitor (WML, GG, ME, RJ, and HHD) had documentation on discharge issues in the present status section of the individual's WRP. **Recommendation 2, June 2007:** Ensure that the individual's progress with regards to behaviors/psychosocial problems is properly documented and available for review with CONREP. **Findings:** According to the Chief of Social Work, unit social workers responsible for the individual confer with the CONREP representatives regarding the individual's progress. The Social Work Chief also added that the CONREP representatives have access to the individual's WRP for review during their liaison visits. **Recommendation 3, June 2007:** Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. **Findings:** This monitor reviewed eight charts (JS, BK, CHK, SL, JC, HD, RS, and MF). One of them (JS) included the skills and supports the individual needs to enable the individual to overcome barriers to discharge. The remaining seven (BK, CH, SL, JC, HD, RS, and MF) did not include the necessary information. **Compliance:** Partial. **Current recommendations**: 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at

		scheduled WRPCs. 2. Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria.
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	**Current findings on previous recommendations:** **Recommendations 1-5, June 2007:** • Ensure that the individual's next placement is identified as soon as possible, so as to equip the individual with appropriate planning and preparation of skills and supports. • Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. • Develop a tool to monitor and track this requirement. • Include these skills and supports in the individual's WRP and use this information to guide appropriate services for the individual. • Ensure that WRPT members focus on this requirement and update the individual's WRP as necessary. **Findings:** PSH audited 22 WRPCs using #4 (*the skills and supports necessary to live in the setting in which the individual will be placed*) from the DMH WRP Discharge Planning and Community Integration Auditing Form to address this recommendation, reporting 27% compliance. This monitor reviewed six charts (RS, MF, SH, JC, AH, and SL). The individuals' expected discharge placements were identified upon admission, as documented in the individual's Social Work assessment and notes and in the individual's WRP case formulation. One of the six (RS) had documentation on the skills needed to transition to the new placement, and the remaining five (MF, SH, JC, AH, and SL) did not have documentation on what skills and supports the individuals needed, and if any were arranged for/provided by PSH.

		Documentation in two of them (MF and RS) showed that the individuals did not meet the discharge criteria even though they were recommended for discharge. It would appear that cases such as these two would not be accepted by CONREP. PSH is using the newly approved DMH WRP Discharge Planning and Community Integration Auditing Form to track the requirement for this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 2. Include these skills and supports in the individual's WRP and use this information to guide appropriate services for the individual. 3. Ensure that WRPT members focus on this requirement and update the individual's WRP as necessary.
E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.	**Current findings on previous recommendations:** **Recommendations 1-4, June 2007:** • Ensure that the individual is an active participant in the discharge planning process. • Implement the DMH WRP Manual regarding the discharge process. • Prioritize objectives and interventions related to the discharge process. • Ensure that the individual understands all of the discharge requirements before leaving the WRPC.

Findings:
According to Veronica Kaufman, Chief of Social Work, staff training was conducted with WRPT members. However, the data obtained through PSH self-evaluation and the monitor's chart review and conference observation showed that implementation by WPRTs on these recommendations continue to be poor.

PSH audited WRPCs using item #12 from the DMH WRP Observation Monitoring Form to address this recommendation, reporting 10% compliance. The table below with its monitoring indicator showing the number of WRP annual conferences due each month (N), the number of WRP annual conferences observed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.

	5/07	6/07	7/07	8/07	9/07	10/07	Mean
N	104	94	75	89	112	107	
n	13	16	4	18	18	5	
%S	13	17	1	20	16	5	
%C # 12	15	6	25	11	0	0	10

This monitor reviewed seven charts (ME, PAB, RA, HHD, RJ, GG, and WML). Three of them (ME, PAB, and RA) had some documentation indicating that discharge matters were discussed and the individual was a participant in the process, and the other four (HHD, RJ, GG, and WML) did not have sufficient information showing the criteria was met. There was a hanging statement in HDD, "Encouraged to read court

		material." This statement was not clear enough to be considered as meeting criteria. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individual is an active participant in the discharge planning process. 2. Prioritize objectives and interventions related to the discharge process. 3. Ensure that the individual understands all of the discharge requirements before leaving the WRPC.
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue and strengthen training to WRPTs to ensure consistent implementation of this requirement. **Findings:** WRPTs are receiving training and guidance from many sources and methods, including formal training from the Psychology and Social Work departments. In addition, PBS team members are participating in WRPCs to assist with discussion and documentation. According to Veronica Kaufman, Chief of Social Work WRP teams will continue to be trained on Discharge Planning and Community integration as part of a WRP training module. **Recommendation 2, June 2007:** Ensure that the monitoring tool addresses the documentation of the results of the team's review of progress in the present status section of the case formulation and of appropriate revisions of the WRP if no

		progress has been made (as required by the DMH WRP Manual). **Findings:** PSH used the recently approved DMH WRP Discharge Planning and Community Integration Auditing Form to address this recommendation. The audit form and the instructions accompanying the audit form do not address this recommendation "the review of progress in the present status section of the case formulation and of appropriate revisions of the WRP if no progress has been made." A number of WRPT members informed this monitor that they are unable to revise WRPs in a timely manner due to lack of progress notes from service providers. **Recommendation 3, June 2007:** Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP and Psychosocial Rehabilitation Services. **Findings:** An analysis of the data provided by PSH, and that obtained by this monitor via staff interviews, chart review, WRPC observation, and interview of individuals and presented in the 'Discharge Planning and Community Integration' section, showed that most of the discharge planning did not meet the requirements of a professionally developed discharge plan, as outlined in the DMH WRP process for discharge planning. **Recommendation 4, June 2007:** Ensure that ADs are updated to make them relevant and in line with EP requirements.

		Findings: This monitor reviewed the updated AD #1.00 (Written Plan for Professional Service, June 1, 2007) and AD #15.42 (Wellness and Recovery Plan, November 12, 2007). The ADs address EP requirements. However, as the analysis of data obtained showed, implementation of these directives is poor. **Compliance:** Partial. **Current recommendations**: 1. Continue and strengthen training to WRPTs to ensure consistent implementation of this requirement. 2. Ensure that the monitoring tool addresses the documentation of the results of the team's review of progress in the present status section of the case formulation and of appropriate revisions of the WRP if no progress has been made (as required by the DMH WRP Manual). 3. Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP and Psychosocial Rehabilitation Services.
E.3.a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual. **Findings:** PSH audited 22 WRPCs using item #6 (*measurable interventions regarding these discharge considerations*) from the DMH WRP

		Discharge Planning & Community Integration Auditing Form to address this recommendation, reporting 32% compliance. This monitor reviewed ten charts (CH, GG, JM, HD, JC, RS, BA, SL, RA, and AH). Six of them (CH, GG, JM, HD, JC, and RS) had the interventions written in behavioral/measurable terms. Four of them (RA, BA, SL, and AH) did not have all the interventions written in behavioral/measurable terms. **Compliance:** Partial. **Current recommendations**: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.
E.3.b	the staff responsible for implementing the interventions; and	**Current findings on previous recommendations:** **Recommendations 1-3, June 2007:** • Ensure that staff members responsible for each intervention are clearly identified in the individual's WRP. • Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. • Ensure that all elements required for fulfilling the intervention section of the WRP are completed. **Findings:** PSH audited 22 WRPCs using item #7 (*the staff responsible for implementing the interventions*) from the DMH WRP Discharge Planning & Community Integration Auditing Form to address this recommendation, reporting 41% compliance.

		This monitor reviewed twelve charts (BK, CH, BA, GNG, RA, RS, JC, JM, HD, MF, JS and SL). Seven of them (BK, CH, BA, GNG, RA, RS, and JC) had listed the staff responsible for implementing the interventions, and five of them (JM, HD, MF, JS, and SL) did not include all the elements required for fulfilling the intervention section of the WRP. **Compliance:** Partial. **Current recommendations**: 1. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. 2. Ensure that all elements required for fulfilling the intervention section of the WRP are completed.
E.3.c	The time frames for completion of the interventions.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Ensure that the review date for each objective is the same as the individual's next scheduled WRPC. **Findings:** PSH audited 22 WRPCs using item #8 (*time frames for completion of the interventions*) from the DMH WRP Discharge Planning & Community Integration Auditing Form to address this recommendation, reporting 33% compliance. This monitor reviewed 13 charts (BK, CH, GG, JM, BA, CG, JS, RS, HD, AH, GNG, RA, and MF). Ten of them (BK, CH, GG, JM, BA, CG, JS, GNG, RA, and MF) had review dates for each active objective. Three of them (HD, RS, and AH) did not have dates for all active objectives or the timelines were not accurate.

		Compliance: Partial. **Current recommendations**: Ensure that the review date for each objective is the same as the individual's next scheduled WRPC.
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	**Compliance:** Partial.
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Identify and address system factors that act as barriers to timely discharge. • Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge. **Findings:** PSH has developed and implemented a tool (Discharge Tracking Form) to track and monitor this recommendation. PSH uses this tool to 1) identify individuals referred for discharge, 2) record the time taken to send report to court and 3) identify delays in getting the recommendation out to the court, and when delay occurs to find remedies for the delay. Since implementation of this tracking form PSH had received six completed tracking forms. The table below with a summary of the information from the tracking form is a summary of the facility's data.

ID #	Staffing	Typed	Forward to MD	Apprvd by FRP	Sign by MD	Return to Prog.	Mailed to crt
1599-570	10/9	10/10	11/7	11/7	11/8	11/9	11/13
1599-547	10/18	10/19	11/6	-	-	11/9	11/13
1600-691	10/23	10/25	11/6	11/8	11/8	11/13	11/13
1599-695	10/25	11/1	11/6	11/8	11/8	11/9	11/13
1599-570	Unknown	11/2	11/7	11/8	11/8	11/9	11/13
1595-503	10/5	10/22	11/7	11/	11/9	11/13	11/13

As the data in the table show, most of the court reports were written within a week. Once received, the court reports were reviewed, approved and returned to the program within three working days, and were subsequently sent to the court within a few days. According to Veronica Kaufman, barriers to timely discharge continue to be external system factors, including availability of beds and court and CONREP acceptance.

Recommendation 3, June 2007:
Ensure that detailed attention is given to reasons for admission, previous assessment and possible discharge settings are taken into account when setting discharge criteria.

Findings:
WRPT members interviewed by this monitor understood this recommendation. Social Work notes and Integrated Psychosocial Assessments are places where an individual's potential placement is indicated. This monitor's review of the contents of eight charts (JL, RA, KH, EJ, RA, MHK, NL, and LQ) and the social work notes, Integrated Assessments, and their corresponding WRPs showed that the case formulation and discharge criteria were aligned with the

		expected placement of the individual upon discharge. **Recommendation 4, June 2007:** Use objective data for all discharge criteria and planning. **Findings:** PSH does not address this recommendation sufficiently. Progress notes are not written for WRPTs to have any form of data to document an individual's progress towards discharge. In addition, WRPTs often fail to properly document data, even when data are available, from behavioral guidelines, PBS plans, and the BY CHOICE program (for example, JL and RA). **Recommendation 5, June 2007:** Ensure regular communication with CONREP in addition to their visits to address discharge barriers of the individual. According to Veronica Kaufman, Chief of Social Work, the situation with CONREP participation is the same as that indicated in the previous review. CONREP continues to see individuals once every six months and make COT visits when recommended. CONREP also regularly participates in 14-day conferences of re-hospitalized individuals. Social Work Service department at PSH continues to communicate with CONREP regarding individuals referred for discharge and discuss with CONREP the reasons for the delays and how to minimize them. **Current recommendations**: Use objective data for all discharge criteria and planning.
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	**Current findings on previous recommendations:** **Recommendations 1-3, June 2007:** • Develop and implement a monitoring and tracking system to address

		the key elements of this requirement. • Document specific assistance provided to the individual when transitioned to a new setting. • Ensure that early in the discharge process, support and assistance that an individual may need to transition to the new setting is discussed with the individual. When appropriate and possible, provide these supports and assistance to the individual when discharged. **Findings:** PSH has chosen to monitor and track this recommendation through item #10 (*individuals receive adequate assistance in transitioning to the new setting*) from the DMH WRP Discharge Planning and Community Integration Auditing Form. Using this item, PSH audited 22 WRPCs, reporting 6% compliance. In April 2007, the Chief of Social Work, Veronica Kaufman, had taken the initiative to hold a focus panel with a number of individuals discharged from PSH. The purpose of this focus panel was to hear from these individuals the problems they had experienced upon discharge from PSH. The individuals had discussed a number of issues that were valuable to PSH in their future planning and preparation of individuals for discharge. For example, the discharged individuals had indicated that 1) they were shocked with their exposure to the real world after leaving PSH, 2) those who had received family therapy found it to be very useful, and 3) a number of medications they had been on at PSH were not part of the formulary in the community. This monitor reviewed nine charts (JS, JL, BK, CH, SL, JC, HD, RS, and MF). Two of them (JS and JL) had documented the assistance the individual would need when discharged. The information for JL was extensive and comprehensive on the list of skills, support, and other assistance she will need when placed in the new environment (this

		information was placed at the end of the discharge criteria). However, the remaining seven charts (BK, CH, SL, JC, HD, RS, and MF) failed to attend to these elements. **Current recommendations**: 1. Document specific assistance provided to the individual when transitioned to a new setting. 2. Ensure that early in the discharge process, support and assistance that an individual may need to transition to the new setting is discussed with the individual, and documented in the individual's WRP.
E.5	For all children and adolescents it serves, each State hospital shall:	The requirements of Section E.5 are not applicable to PSH because it does not serve children or adolescents.
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	Summary of Progress on Psychiatric Services: 1. PSH recently implemented an automatic stop date of 15 days for PRN medication use. 2. PSH has improved its auditing methodology and data presentation regarding psychiatric medication management. 3. PSH has conducted adequate data analysis regarding some areas of low compliance with psychiatric medication management. 4. PSH has made some progress in the review, aggregation and analysis of ADR- and medication variance-related data. **Summary of Progress on Psychological Services:** 1. PBS teams are better trained and organized. 2. PBS teams now assist unit psychologists with behavior guidelines. 3. PBS teams now participate in WRPCs, and work with WRPTs on matters related to the individual's maladaptive behaviors, and assist the teams on proper documentation. 4. PSH has set up a trigger system that includes participation by psychology team members. The psychology department in turn has set up an information flow system to attend to the triggers and determine the nature of services to be provided. 5. Structural/functional assessments are now routinely conducted prior to development and implementation of PBS plans. 6. Fidelity checks are now routinely conducted as part of the implementation process on behavioral interventions. 7. The referral process is systematized, and the PBS-BCC checklist is used on all referrals. 8. Monthly reviews and tracking and monitoring of behavioral intervention plans have been established. 9. Documentation of PBS plans in the WRPs has improved. 10. BCC functioning has improved. Meetings are regularly scheduled, and attendance at these meetings has improved.

	11. Neuropsychology Consultation Service has increased the hours of Mall services provided. 12. BY CHOICE program is implemented facility- wide. 13. Mall hours offered meets EP requirement. 14. Ninety-six percent of the substance abuse course facilitators have received training/certification. 15. PSH has tapped into incorporating individuals in the facility as facilitators in Mall services. PSH is training 24 peer facilitators at this time. 16. PSH with support from its CRIPA consultant, Dr. Nirbhay Singh has developed a system-wide PBS curriculum. The system-wide PBS plan is to be implemented by the beginning of 2008. **Summary of Progress on Nursing Services:** 1. Nursing has revised a number of policies and procedures in alignment with the EP. 2. Systems have been developed and implemented to track compliance with competency-based training. 3. Most of the monitoring instruments have been developed and implemented addressing the requirements of the EP for Nursing Services. **Summary of Progress on General Medical Services:** 1. PSH has revised its ADs and policies and procedures in an effort to correct the process deficiencies outlined in the previous monitor's reports. 2. PSH has refined its monitoring indicators regarding laboratory testing, including radiology and EKG. **Summary of Progress on Infection Control:** 1. Infection Control is now generating data reflecting compliance rates in alignment with the EP. 2. Most of the monitoring instruments have been developed and

		implemented addressing the requirements of the EP for Infection Control. **Summary of Progress on Dental Services** 1. Dental Services is now working on statewide monitoring instruments in alignment with the EP. 2. PSH's Dental Department is generating more data that accurately reflects the services it provides.
1. Psychiatric Services		
		Methodology: <u>Interviewed</u>: 1. John Thiel, MD, Senior Psychiatrist 2. Behnam Luka Behnam, MD, Senior Psychiatrist 3. Regina Olender, RN, Nurse Administration 4. Debra Whaley, Standards Compliance Department 5. Michael Cummings, MD, PSH Psychopharmacology Consultant 6. Stephen Mauer, MD, Chief of Medical Staff 7. Wadsworth Murad, MD, Acting Chief of Psychiatry 8. Richard Plon, PharmD, Pharmacy Representative, Pharmacy and Therapeutics Committee <u>Reviewed</u>: 1. Charts of 49 individuals: MLD, DS, CG, CW, AA, MWM, SO, KAW, BO, SSM, NBM, GCC, TSM, GEO, AWS, JEP, NBM, HMR, LCR, DMB, EA, MB, JWB, KLC, DG, JW, LB, AJW, SQS, CH-3, RTN, JEF, AH, RP, JJ, ADT, JLC, YR, RB, DC, ARB, RAS, GWD, KAB, JD, YT, LER, HPR and CWM 2. California Department of Mental Health (DMH) Psychotropic Medication Policies and Guidelines (June 2007) 3. PSH Staff Psychiatrist Manual 4. PSH list of individuals with Psychotropic Medications, Diagnoses

		and Attending Physicians 5. PSH database regarding intra-class and inter-class polypharmacy 6. PSH Admission Psychiatric Assessment Auditing Form 7. Admission Psychiatric Assessment summary data (June to October 2007) 8. PSH Integrated Psychiatric Assessment Auditing Form 9. Integrated Psychiatric Assessment Auditing summary data (May to June and August to September 2007) 10. PSH Physician Progress Note Auditing Form 11. Physician Progress Note Auditing summary data (May to September 2007) 12. PSH Medication Monitoring PRN Auditing Form 13. PRN Auditing summary data (August 2007) 14. PSH Medication Monitoring Stat Auditing Form 15. Stat Auditing summary data (September 2007) 16. DMH Nursing Administration of PRN Medications Auditing Form 17. Nursing Administration of PRN Medications Auditing summary data (May to October 2007) 18. DMH Nursing Administration of Stat Medications Auditing Form 19. Nursing Administration of Stat Medications Auditing summary data (May to October 2007) 20. PSH Medication Monitoring Benzodiazepine Auditing Form 21. Benzodiazepine Auditing summary data (June 2007) 22. PSH Medication Monitoring Anticholinergic Auditing Form 23. Anticholinergic Auditing summary data (May 2007) 24. PSH Medication Monitoring Polypharmacy Auditing Form 25. Polypharmacy Auditing summary data (August 2007) 26. PSH Medication Monitoring New generation Antipsychotics Auditing Form 27. New generation Antipsychotics Auditing summary data (September 2007) 28. PSH database regarding individuals suffering from tardive dyskinesia

		29. PSH Medication Monitoring Tardive dyskinesia Auditing Form 30. Tardive dyskinesia Auditing summary data (September 2007) 31. PSH Nursing Policy and Procedure #537 A, Adverse Drug Reactions (November 2007) 32. Adverse Drug Reaction Reports (May to October 2007) 33. PSH data regarding Drug utilization Evaluations (May to October 2007) 34. Nursing Policy and Procedure #511, Medication Variances (May 2007) 35. Pharmacy and Therapeutics Medication Variance Policy (September 2007) 36. AD #10.48, Medication Variances (November 2007) 37. PSH data regarding medication variances (August to October 2007)
F.1.a	Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Implement the new statewide individualized medication guidelines and DUE instruments across state facilities. **Findings:** California DMH Psychotropic Medication Policies and Guidelines have been implemented statewide and were approved by the PSH Pharmacy and Therapeutics (P&T) Committee and Medical Executive Committee (MEC) in April 2007. Since the initial version of the guidelines was issued (March 2007), the statewide committee has implemented updates of these guidelines. The most recent version (June 2007) included the following updates: 1. Laboratory monitoring requirements regarding the use of clozapine, olanzapine, risperidone, ziprasidone and divalproex; 2. Clinical monitoring requirements regarding the use of lamotrigine; 3. Precautions/contraindications regarding the use of olanzapine and

		divalproex; and 4. Therapeutic Review Committee oversight regarding upper dose limits for combinations of oral and depot formulations of the same medications. The guidelines have yet to include the use of other mood stabilizers (e.g. lithium, carbamazepine and oxcarbazapine) and antidepressants (e.g. bupropion, venlafaxine, and mirtazapine). DMH DUE monitoring instruments that are aligned with the DMH individualized medication guidelines. The monitoring tools for NGAs and SSRIs were developed locally at PSH. All these instruments are being reviewed statewide for a complete and final set of tools to be used by all hospitals. **Recommendation 2, June 2007:** Ensure that the PSH staff psychiatrist manual includes the same individualized DUE instruments regarding the use of new generation antipsychotics and mood stabilizers. **Findings:** The PSH staff psychiatrist manual currently includes DUE instruments that align with the DMH individualized medication guidelines. The facility plans to update the manual when all medication monitoring tools have been standardized statewide. **Recommendation 3, June 2007:** Same as in D.1.c, D.1.d and D.1.e. **Findings:** Same as in D.1.c, D.1.d and D.1.e.

		Recommendation 4, June 2007: Standardize the monitoring forms and other mechanisms of review across state facilities. Ensure that compliance rates derived from internal monitoring are based on a monthly review of a stratified 20% sample. This recommendation applies to all relevant items in Section F. **Findings:** As mentioned earlier, statewide efforts are underway to standardize all medication monitoring tools. At this time, PSH uses its own monitoring tools to assess compliance with all requirements of the EP in the area of medication management. In the process of internal monitoring, the Standards Compliance Psychologist generates a 20% random monthly sample stratified by physician for all required monitoring. Due to inadequate staffing and lack of full-time Senior Psychiatrists, the facility has been unable to ensure monitoring of at least a 20% sample for all categories. As mentioned in C.1.a, PSH currently has two full-time acting Senior Psychiatrists and it is anticipated that two more full-time acting Senior Psychiatrists will be appointed by January 2008. **Recommendation 5, June 2007:** Monitor this requirement utilizing DUE instruments related to the new individualized medication guidelines. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: 1. Implement individualized medication guidelines that include specific information regarding indications, contraindications, clinical and

<table>
<tr><td></td><td></td><td>laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines.
2. Finalize statewide efforts to standardize all medication monitoring instruments.
3. Continue to monitor this requirement based on at least a 20% sample, using standardized indicators, and provide data analysis regarding low compliance with corrective actions.
4. Present data regarding the use of anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotic medications in corresponding cells (F.1.c and F.1.d).</td></tr>
<tr><td>F.1.a.i</td><td>specifically matched to current, clinically justified diagnoses or clinical symptoms;</td><td>PSH used the PSH Admission Psychiatric Assessment, Integrated psychiatric Assessment and Physician Progress Note Auditing Forms to assess compliance with this requirement. The overall mean reliability was not determined. The following is a summary of the data, including the name of the tool, months of monitoring, average sample size, monitoring indicators and corresponding mean compliance rates:

<table>
<tr><td colspan="3">PSH Admission Psychiatric Assessment Auditing Form</td></tr>
<tr><td>Months:</td><td colspan="2">June to October 2007</td></tr>
<tr><td>Sample:</td><td colspan="2">Average of 32% of admissions per month</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="2">Rationale for prescribed medication is documented</td><td>68%</td></tr>
</table>

<table>
<tr><td colspan="4">PSH Integrated Psychiatric Assessment Auditing Form</td></tr>
<tr><td>Months:</td><td colspan="3">May-June and August-September 2007</td></tr>
<tr><td>Sample:</td><td colspan="3">Average of 20% of integrated assessments due per month</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>1.</td><td>Diagnostic formulation is documented</td><td colspan="2">72%</td></tr>
<tr><td>2.</td><td>Target symptoms are identified</td><td colspan="2">77%</td></tr>
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<tr><td>3.</td><td>If appropriate, there is documentation justifying continuing currently prescribed medications</td><td>68%</td></tr>
<tr><td>4.</td><td>If appropriate, rationale for the PRN/STAT usage</td><td>41%</td></tr>
</table>
<table>
<tr><td colspan="3">PSH Physician Progress Note Auditing Form</td></tr>
<tr><td>Months:</td><td colspan="2">May-September 2007</td></tr>
<tr><td>Sample:</td><td colspan="2">Average of 6% of the individuals in the hospital for more than seven days</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>1.</td><td>Identified target symptoms are documented</td><td>48%</td></tr>
<tr><td>2.</td><td>Rationale for current psychopharmacology plan is documented</td><td>48%</td></tr>
<tr><td>3.</td><td>The individual's response to pharmacologic treatment is documented</td><td>64%</td></tr>
<tr><td>4.</td><td>The rationale for continuation of medications is documented</td><td>49%</td></tr>
<tr><td>5.</td><td>The rationale for proposed plans is documented</td><td>48%</td></tr>
</table>
The facility anticipates improved compliance after development and implementation of a standardized format for progress note documentation.
</td>
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<tr>
<td>F.1.a.ii</td>
<td>prescribed in therapeutic amounts, as dictated by the needs of the individual served;</td>
<td>Same as in F.1.a.i. The facility has yet to implement monitoring of the dosage requirements based on the individualized medication guidelines.</td>
</tr>
<tr>
<td>F.1.a.iii</td>
<td>tailored to each individual's symptoms;</td>
<td>Same as in F.1.a.i (PSH Integrated Psychiatric Assessment Auditing form, indicator #2 and PSH Physician Progress notes Auditing Form, indicator #1).</td>
</tr>
<tr>
<td>F.1.a.iv</td>
<td>monitored for effectiveness against clearly identified target variables and time frames;</td>
<td>Same as in F.1.a.i (PSH Physician Progress Note Auditing Form, indicators #1 through 5).</td>
</tr>
</table>

F.1.a.v	monitored appropriately for side effects;	The PSH Physician Progress Notes Auditing Form contains two indicators that are relevant to this requirement (*Monitoring of side effects, including sedation and AIMS quarterly, if applicable*). However, the facility did not present these data in this cell. Instead, the facility presented data regarding the use of anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotic medications. While these data are also relevant, the information should be presented for corresponding requirements in F.1.c and F.1.d.
F.1.a.vi	modified based on clinical rationales;	Same as in F.1.a.i (PSH Physician Progress Note Auditing Form, indicators #4 and 5).
F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	Same as in F.1.v. (first indicator).
F.1.a.viii	Properly documented.	The data provided by the facility did not include an average of the above sub-cells, as it should have.
F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Identify barriers to adequate compliance and develop strategies to resolve these barriers (e.g. automatic stop dates for PRN medication in seven days). **Findings:** PSH recently changed the automatic stop date for PRN medication use from 45 days to 15 days to improve compliance with EP requirements in this area. Auditing for that requirement reportedly began November 1, 2007 and the facility plans to analyze data and develop further corrective actions as needed.

Recommendation 2, June 2007:
Continue to monitor the use of PRN and Stat medications, based on adequate sample sizes.

Findings:
PSH used the PSH Medication Monitoring PRN and Stat Auditing Forms to assess compliance. The facility reviewed samples of 3% and 18% of the number of PRN and Stat medications, respectively. The PRN monitoring was conducted in August 2007 and Stat monitoring in September 2007.The overall mean reliability was not determined. Statewide efforts are underway to standardize the indicators, finalize monitoring instructions and improve alignment with EP requirements. The facility's data were also presented in D.1.f.vi. The following is a summary outline of the indicators and corresponding mean compliance rates:

PRN Medications (Psychiatry)		
1.	*Order for PRN medication specifies behavioral indications that involve risk, without generic terms*	44%
2	*Indications for PRN use are documented*	36%
3.	*Rationale for chosen PRN medication is documented*	28%
4.	*Review of PRN medications used during the interval is documented*	24%
5.	*Strategy to modify regular treatment based upon review of use is documented*	24%
6.	*There is documentation that regular treatment is modified based on patterns of PRN use, as appropriate*	27%
7.	*Evidence of symptom reduction and/or improved participation in therapeutic activities as a result of PRN use is documented*	46%

Stat Medications (Psychiatry)				
1.	*A psychiatrist conducts face-to-face assessment of the individual within 24 hours of the administration of Stat medication*	78%
2.	*Reason for Stat administration is documented*	67%
3.	*Individual's response to Stat medication is documented*	61%
4.	*As appropriate, adjustment of current treatment is documented*	0%
5.	*As appropriate, adjustment of current diagnosis is documented*	0%

In addition, PSH assessed compliance regarding nursing administration of PRN and Stat medications. Using the DMH Nursing Administration of PRN and Stat Medications Auditing Forms, the facility reviewed average sample sizes of 3% and 22% of the numbers of PRN and Stat medications administered each month, respectively (May to October 2007). The following is a summary outline of the indicators and corresponding mean compliance rates:

PRN Medications (Nursing)		
1.	*Nursing staff assessed the individual within one hour of administration of the psychiatric PRN medication*	57%
2.	*Nursing staff documents the individuals response to the PRN medication*	45%
Stat Medications (Nursing)		
3.	*Nursing staff safely administers STAT medications*	99%
4.	*Nursing staff document the circumstances requiring STAT medications*	61%
5.	*The documentation includes interventions that were attempted prior to the administration of STAT medications*	35%

6.	*Nursing staff assessed the individual within one hour of administration of the psychiatric STAT medication*	50%
7.	*Nursing staff documents the individuals response to the STAT medication*	42%

Other findings:
See D.1.f for this monitor's review of the appropriateness of PRN/Stat medication use. These reviews and other chart reviews by this monitor showed that PSH has yet to make progress in correcting the deficiencies outlined in this and previous reports regarding the use of PRN and Stat medications.

Compliance:
Partial.

Current recommendations:
1. Implement current procedure to ensure that all PRN orders for Psychotropic medications are limited to no more than 15 days of use before the orders are reviewed and rewritten as necessary. This time limit should be gradually shortened to three days of use.
2. Monitor the use of PRN and Stat medications based on at least a 20% sample and provide data analysis regarding low compliance with corrective actions.
3. Continue to report data regarding PRN and Stat medications to address EP requirements regarding each of the following:
   a. Psychiatric documentation of PRN medication use;
   b. Psychiatric documentation Stat medication use;
   c. Nursing documentation of PRN medication use; and
   d. Nursing documentation of Stat medication use.
4. Provide ongoing feedback and mentoring by Senior Psychiatrists to ensure correction of the deficiencies noted by this monitor.

<table>
<tr>
<td>F.1.c</td>
<td>Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.</td>
<td>
Current findings on previous recommendations:

Recommendation 1, June 2007:
Continue to use current monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy. Ensure that the justification of use is consistent with current generally accepted standards.

Findings:
PSH used the PSH Medication Monitoring Benzodiazepine, Anticholinergic and Polypharmacy Auditing Forms to assess compliance. The data are based on samples of 37% (June 2007), 24% (May 2007) and 20% (August 2007) of the number of individuals receiving benzodiazepines, anticholinergics and polypharmacy per month, respectively. The overall mean reliability was not determined. Statewide efforts are underway to standardize the indicators, finalize monitoring instructions and improve alignment with EP requirements. The following is a summary outline, including the monitoring indicators and corresponding mean compliance rates.

<table>
<tr><td colspan="3">Benzodiazepines</td></tr>
<tr><td>1.</td><td>Documentation justifies regular use of benzodiazepine for anxiety or other diagnosis/indication</td><td>72%</td></tr>
<tr><td>2.</td><td>Cognitive impairment (risk is documented)</td><td>35%</td></tr>
<tr><td>3.</td><td>Sedation (risk is documented)</td><td>30%</td></tr>
<tr><td>4.</td><td>Gait unsteadiness or falls (risk is documented)</td><td>17%</td></tr>
<tr><td>5.</td><td>Substance Abuse (risk is documented)</td><td>25%</td></tr>
<tr><td>6.</td><td>Respiratory depression for those with underlying respiratory problems (risk is documented)</td><td>33%</td></tr>
<tr><td>7.</td><td>Toxicity if used in individuals with liver impairment (long acting agents)</td><td>14%</td></tr>
<tr><td>8.</td><td>TRC consult approval obtained for use over two months.</td><td>47%</td></tr>
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		9.	*Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risks*	74%

Anticholinergics		
1.	*Documentation includes extrapyramidal indications*	48%
2.	*Documentation justifies regular use for non-EPS indication*	30%
3.	*Cognitive impairment (risk is documented)*	10%
4.	*Sedation, if using antihistaminic e.g. diphenhydramine (risk is documented)*	20%
5.	*Gait unsteadiness/falls (risk is documented)*	18%
6.	*Blurred vision, constipation or urinary retention (risk is documented)*	18%
7.	*Worsening narrow angle glaucoma, if present (risk is documented)*	NA
8.	*Substance abuse, especially trihexyphenidyl (risk is documented)*	16%
9.	*Worsening TD if present*	14%
10.	*TRC consult approval obtained for use greater than two months*	17%
11.	*Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk*	56%

Polypharmacy		
1.	*There is documentation in the Physician Progress Note (PPN) clearly identifying the target symptoms*	98%
2.	*There is documentation in the PPN justifying the need for inter-class polypharmacy*	30%
3.	*There is documentation in the PPN justifying the need for intra-class polypharmacy*	48%
4.	*There is documentation in the PPN that elucidates the risks of polypharmacy*	6%

5.	*Polypharmacy was modified in a timely manner to ensure proper indications and minimize risks*	96%
6.	*A TRC consult obtained if polypharmacy use exceeded 60 days*	59%
7.	*If a TRC consult was obtained and not followed, there is documentation in the PPN justifying the reason*	100%

Recommendation 2, June 2007:
Address the accuracy of intra-class polypharmacy data.

Findings:
Review of PSH's current polypharmacy data indicates that the facility has implemented this recommendation

Recommendation 3, June 2007:
The staff psychiatrist manual may include a section for all DUE instruments including those used for benzodiazepines, anticholinergics, polypharmacy and PRN/Stat and the new instruments that accompanied the DMH individualized medication guidelines. The current array of policies and guidelines may be simplified and consolidated with these instruments.

Findings:
PSH has a plan to update the manual when all medication monitoring tools have been standardized for statewide use.

Recommendation 4, June 2007:
Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.

Findings:
PSH yet to implement this recommendation. PSH reported that the process of identifying trends and providing feedback for individual

practitioners will involve Senior Psychiatrists when they are hired. For the period of May to October, 2007, one acting Senior Psychiatrist reviewed all orders for benzodiazepines, anticholinergics, and polypharmacy and selected specific cases based on duration of prescription. He reviewed the individuals' charts and provided written feedback to the prescribing physicians. The facility did not provide data regarding results of this review.

Other findings:
Chart reviews by this monitor revealed that too many individuals are still receiving long-term regular treatment with benzodiazepines (alprazolam, lorazepam or clonazepam) without documented justification. The following table outlines examples of this practice in the presence of diagnoses that increase the risks of treatment for the individuals:

Individual	Medication	Diagnosis
GRH	Alprazolam	Polysubstance Dependence (Methamphetamine, Cocaine and Alcohol)
SRB	Lorazepam (and lorazepam PRN)	Alcohol Dependence and Cannabis Abuse
JS	Lorazepam	Polysubstance Dependence
RAG	Lorazepam and (Lorazepam PRN)	Alcohol Abuse and Cannabis Abuse
APC	Clonazepam (till 11/26/07)	Polysubstance Dependence

PIM	Lorazepam (and benztropine)	Polysubstance Dependence and Cognitive Disorder, NOS
OVM	Clonazepam	Borderline Intellectual Functioning
RAS	Clonazepam	Polysubstance Dependence
JCS	Clonazepam	Cognitive Disorder, NOS

The facility's database regarding individuals currently receiving benzodiazepines contains, by error, a number of individuals (e.g. SB and EYB) who are not currently receiving these medications and have not received these medications recently. In addition, the database includes several errors in the current diagnoses of these individuals (RAS and JCS).

The following table outlines this monitor's findings of examples of unjustified long-term use of anticholinergic medications despite the presence of diagnoses that increase the risk of treatment.

Individual	**Medication**	**Diagnosis**
RC	Diphenhydramine and hydroxyzine	Dementia Due to Other medical Condition
ARB	Benztropine	Tardive Dyskinesia
RAS	Trihexyphenidyl	Tardive Dyskinesia
RA	Benztropine	Mild Mental Retardation
PIM	Benztropine (and lorazepam)	Cognitive Disorder, NOS
RWT	Benztropine	Borderline Intellectual Functioning

Reviews by this monitor of the charts of individuals receiving various forms of polypharmacy revealed general evidence of inadequate documentation of the rationale for polypharmacy and of associated

risks as well as attempts to simplify/optimize the regimen. The following are examples.

Individual	Medications	Diagnosis
RAS	Clozapine, clonazepam, trihexyphenidyl, paroxetine and lamotrigine	Schizoaffective, Bipolar Type, Polysubstance Dependence, Tardive Dyskinesia.
JJ	Olanzapine and quetiapine	Schizoaffective Disorder, Bipolar Type and Diabetes Mellitus
JEA	Clozapine, haloperidol and Olanzapine	Schizophrenia, Paranoid, Continuous
RB	Clozapine, Olanzapine, haloperidol (till November 13, 2007) and benztropine	Schizophrenia, Undifferentiated
AJV	Olanzapine, risperidone (and divalproex)	Schizoaffective Disorder, Bipolar Type,
RDT	Olanzapine and risperidone (and divalproex)	Schizophrenia, Paranoid,
FS	Clozapine, risperidone and lithium	Schizophrenia, Paranoid, Diabetes Mellitus
CH-3	Olanzapine, risperidone and divalproex	Schizophrenia, Paranoid
MGG	Olanzapine, risperidone and ziprasidone	Schizophrenia, Paranoid

Compliance:
Partial.

Current recommendations:
1. Standardize monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy for use across

		facilities and ensure that these instruments are aligned with the DMH medication guidelines. 2. Continue monitoring of the use of benzodiazepines, anticholinergics and polypharmacy based on at least a 20% sample, using standardized indicators, and provide data analysis regarding low compliance with corrective actions. 3. Provide ongoing feedback and mentoring by Senior Psychiatrists to ensure correction of the deficiencies noted by this monitor. 4. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.
F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Same as in F.1.a. **Findings:** Same as in F.1.a. **Recommendation 2, June 2007:** Same as in F.1.g. **Findings:** Same as in F.1.g. **Recommendation 3, June 2007:** Ensure that all monitoring indicators are aligned with the new individualized medication guidelines. **Findings:** PSH currently uses monitoring indicators that are aligned with the guidelines.

Other findings:
PSH used the PSH Medication Monitoring New Generation Antipsychotic Auditing Form. The following table outlines the total population of individuals receiving different antipsychotic agents (N), the number of individuals reviewed (n), sample sizes (%S), monitoring indicators and mean compliance rates for each indicator. This audit was conducted in September 2007.

	Clozapine	Ziprasidone	Quetiapine	Olanzapine	Risperidone	Aripiprazole	Mean
N	102	147	265	502	409	228	
n	12	12	23	33	37	20	
%S	12	8	9	7	9	9	
1. Family/personal risk factors documented in chart.	25	8	27	21	31	37	26
2. Indications for use are present.	75	75	91	84	86	95	86
3. Absolute contraindications are absent	67	78	78	64	67	81	71
4. Precautions are absent unless benefit outweighs risk with documentation	58	80	75	54	48	75	62
5. PPN documents potential and actual risk for each medication used	55	33	36	41	34	39	39
6a. Justification documented in PPN for individual with a diagnosis of dyslipidemia	29	40	18	19	30	14	24

		6b. Justification documented in PPN for individual with a diagnosis of diabetes	0	25	11	14	23	14	16
		6c. Justification documented in PPN for individuals with a diagnosis of obesity	17	40	27	16	22	13	21
		7. Dose initiation meets requirements	64	64	70	73	76	78	72
		8. Dose iteration meets requirements	64	75	81	73	81	84	77
		9. If side effects present, treatment was modified appropriately and time to reduce side effects.	100	50	33	50	67	78	60
		10a. FBS obtained initially	50	75	86	81	78	85	79
		10b. FBS obtained quarterly	33	50	33	57	50	43	46
		11a. Lipid panel obtained initially	50	83	87	82	75	85	79
		11b. Lipid panel obtained quarterly	33	50	33	57	50	43	46
		12. Electrolytes obtained initially	42	75	82	74	73	85	74
		13a. Prolactin level obtained initially as	0	14	7	11	16	17	12
		13b. Prolactin level annually	0	n/a	0	100	50	n/a	50
		14. Liver function tests obtained initially	50	82	83	81	76	85	78
		15 Amylase obtained quarterly	0	0	27	30	16	8	17
		16. Lipase quarterly	0	0	27	30	16	8	17

		17. Vitals initially and specific to medication	75	75	82	81	73	90	79
		18a. Weight/BMI initially and specific to medication	67	83	77	79	68	80	75
		18b. Weight/BMI monthly	60	67	50	85	82	71	72
		19. If there was a trigger for weight gain, was appropriate follow-up provided.	17	50	11	29	35	33	28
		20a. Waist circumference initially and specific to medication	58	64	57	64	50	59	58
		20b. Waist circumference annually	100	100	50	86	50	60	71
		21a. EKG obtained initially	36	60	61	67	69	67	63
		21b. EKG obtained annually	67	100	0	25	60	50	47
		22. If prescribed a concurrent med that prolongs the QTC, an EKG was done semiannually	40	50	13	20	17	25	24
		23a. AIMS obtained	58	67	55	61	68	67	63
		23b. AIMS annually	100	100	100	0	33	2	64
		24. If hyperprolactemia present, was justification documented for continuing risperidone.	0	0	20	11	7	0	8
		25a. Breast examination initially and specific to medication	0	43	29	28	45	22	33

25b. Breast examination monthly	50	n/a	n/a	0	0	n/a	17
26. If an unstable seizure disorder present, was a neuro consultation ordered.	n/a	50	50	100	75	0	64

This monitor's review of the above data indicates that the indicators are not always aligned with the standards outlined in the DMH individualized medication guidelines. For example, the guidelines include a requirement for semiannual (not quarterly) monitoring of FBS and lipid profile in individuals receiving aripiprazole, but the facility reports compliance data based on quarterly monitoring. In addition, the facility reports compliance data regarding quarterly amylase monitoring for individuals receiving aripiprazole. Monitoring of serum amylase is not required for these individuals as per the guidelines.

PSH reviewed the data regarding compliance with all the above indicators. The facility reported that the results will be presented to the P&T Committee and the members of the Department of Psychiatry for corrective actions. In addition, one Senior Psychiatrist has begun the process of providing feedback to individual psychiatrists regarding these data.

This monitor reviewed the charts of 16 individuals who are receiving new-generation antipsychotic agents and are diagnosed with a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the documented metabolic disorder(s):

Individual	**Medication (s)**	**Diagnosis**
DG	Olanzapine	Diabetes Mellitus
JW	Olanzapine	BMI >30

		LB	Olanzapine	BMI >30
		AJW	Olanzapine	BMI >30
		SQS	Olanzapine	Diabetes Mellitus
		CH-3	Olanzapine and risperidone	Obesity
		RTN	Risperidone	Diabetes Mellitus
		JEF	Risperidone	Obesity
		AH	Risperidone	Diabetes Mellitus, Obesity and Hyperlipidemia
		RP	Risperidone	Diabetes Mellitus and Obesity
		JJ	Quetiapine and olanzapine	Diabetes Mellitus and Hyperlipidemia
		ADT	Quetiapine	Diabetes Mellitus and Hyperlipidemia
		JLC	Clozapine	Diabetes Mellitus and Dyslipidemia
		YR	Clozapine	Diabetes Mellitus
		RB	Clozapine	BMI >30
		DC	Clozapine	BMI >30 and Hypertriglyceridemia

This review showed that, in general, the facility provides adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. However, deficiencies still exist in the following areas:

1. Frequency of required laboratory monitoring (cholesterol and/or triglycerides) in individuals who are overweight (JW and CH-3) and/or suffering from diabetes mellitus (AH and YR) and are taking high-risk antipsychotic agents;
2. Frequency of required laboratory monitoring (serum amylase) for individuals who are taking high-risk antipsychotic agents (AJW);
3. WRP documentation of diabetes mellitus as a diagnosis (RTN and ADT);

		4. WRP documentation of dyslipidemia as a diagnosis or a focus despite supporting laboratory findings in the chart (RTN, and SQS); 5. Laboratory monitoring of prolactin levels in female individuals who are receiving risperidone (JEF and RP); 6. Physician documentation of a significant increase in triglyceride level in an individual suffering from diabetes mellitus (ADT); 7. Physician documentation of significant increase in cholesterol level in an individual receiving combination of high-risk medications (RDT); 8. Physician documentation of interventions to address persistent dyslipidemia in an individual suffering from diabetes mellitus (SQS); and 9. Physician documentation of risks and benefits of use and of attempts to use safer treatment alternatives (in most charts). **Compliance:** Partial. **Current recommendations:** 1. Review all individuals who are diagnosed with diabetes mellitus and are receiving new generation antipsychotic agents to determine: a) type of medication used; b) rationale for use (if individuals are receiving clozapine, olanzapine, risperidone and/or quetiapine) and c) status of diabetes management (as assessed by the monitoring tool used in section F.7). 2. Standardize the monitoring instruments relevant to this requirement for use across facilities and ensure that the indicators are aligned with the standards in the individualized medication guidelines. 3. Monitor this requirement based on a 20% sample of the appropriate total target population and provide data analysis and update regarding corrective actions.

		4. Provide ongoing feedback and mentoring by Senior Psychiatrists to improve compliance and correct the deficiencies outlined by this monitor above and in the previous report.
F.1.e	Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.	**Current findings on previous recommendations:** **Recommendations 1-3, June 2007:** • Standardize the TD monitoring instrument across state facilities. • Ensure that the diagnoses listed in the WRP are aligned with those listed in psychiatric documentation, including TD. • Ensure that TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation. **Findings:** Statewide efforts are in progress to finalize a TD monitoring instrument that aligns with the above three recommendations. **Recommendations 4-5, June 2007:** • The staff psychiatrist manual should address Recommendations 2 and 3 above. • Identify barriers to compliance and provide strategies to resolve these barriers. **Findings:** PSH has yet to implement these recommendations. **Other findings:** PSH used the PSH Medication Monitoring Tardive Dyskinesia (TD) Auditing Form to assess compliance (September 2007). The facility reviewed a sample of 59% of the known number of individuals suffering from TD. PSH acknowledged that its estimate of the total target population may not be accurate due to possible underreporting of

individuals suffering from tardive dyskinesia. In an effort to improve this estimate, the facility reported a plan to conduct neurological assessments of all individuals in a 20% stratified random sample and to compare prevalence found by the neurologist to that found by the attending psychiatrists. The following is an outline of the facility's monitoring indicators and corresponding mean compliance rates.

1.	*Do monthly progress notes (PPNs) for past three months regarding prescribed antipsychotic medications discuss documented benefits?*	100%
3.	*Do PPNs for past three months regarding prescribed antipsychotic medications discuss tolerability of the medication?*	100%
4.	*If a conventional antipsychotic is used, is there evidence in the PPN of justification of using the older generation medication?*	100%
5.	*Was an AIMS exam done on admission?*	42%
6.	*Was an annual exam done at time of last annual physical exam?*	85%
7.	*If this individual has TD, was a new AIMS exam done every three months?*	0%
8.	*If this individual has a history of TD, was an AIMS exam done every three months?*	58%
9.	*Do PPNs for past three months indicate that antipsychotic treatment has been modified for individuals with TD, a history of TD or a positive AIMS test to reduce risk?*	90%

This monitor reviewed the charts of nine individuals (ARB, RAS, GWD, KAB, JD, YT, LER, HPR and CWM) who have a documented diagnosis of tardive dyskinesia. The facility recognizes that the current database does not identify all individuals who may be suffering from this disorder. The review showed the following pattern of deficiencies:

		1. The WRP does not include TD as a diagnosis (CWM). 2. The WRP identified TD as a diagnosis but did not include corresponding focus, objective/interventions to address this disorder (GWD and HPR). 3. The WRP includes an objective and interventions that are not appropriate for individuals suffering from abnormal movement disorder (ARB and KAB), including that anticholinergic medication is being provided as a regular treatment (in fact this is potentially harmful) and that the individual's objective is to voice an understanding of his need to take this medication. 4. The WRP includes objectives that are vague and not necessarily beneficial for the individuals. 5. Regular long-term treatment with anticholinergic medications, including benztropine (ARB) and trihexyphenidyl (RAS) is provided without documented justification and assessment of potential risks for individuals suffering from TD. 6. AIMS test was not conducted on a quarterly basis as required for most of the individuals reviewed (ARB, RAS, GWD, KAB, JD and CWM). 7. There is no documentation in the psychiatric progress notes of the status of the involuntary movement disorder (JD, YT and GWD). **Compliance:** Partial. **Current recommendations**: 1. Standardize TD monitoring tool and ensure that the indicators address the deficiencies identified by this monitor above and in the previous report. 2. Monitor this requirement in all individuals who are diagnosed with abnormal movement disorder or have history of this disorder and provide data analysis regarding low compliance with corrective

		actions. 3. Develop and implement a policy and procedure to ensure that: a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD; b. TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation; c. The individuals receive appropriate periodic screening; and d. The individuals receive care at a specialized TD clinic. 4. Update the staff psychiatrist manual to include the standards outlined in the policy/procedure.
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Identify barriers to increasing the reporting of ADRs and develop and implement corrective actions. **Findings:** PSH has identified the following barriers: 1. Lack of physician understanding of the definition of an ADR; 2. Lack of pharmacy staff available to follow up suspected ADRs reported by nursing staff; and 3. Lack of physician time to complete paperwork for all ADRs as defined in policy. In an effort to improve the current system of ADR reporting, the facility's P&T Committee revised the ADR policy (#537A) on November 7, 2007. The revised policy, which has yet to be implemented, includes adequate mechanisms ensure the following functions: 1. Reporting of ADRs by physicians and nursing staff;

		2. Review of the reports and classification of ADRs by the pharmacist; 3. Analysis of the data by an ADR Clinical Review Team; 4. Further analysis and performance of Intensive Case Analysis, if needed, by the P&T Committee; and 5. Final review by the Medical Executive Committee (MEC) for performance improvement recommendations, as indicated. **Recommendation 2, June 2007:** Develop written instructions to all clinicians regarding significance and proper methods in reporting, investigating and analyzing ADRs. **Findings:** PSH did not present data regarding this recommendation. **Recommendation 3, June 2007:** Implement recent revisions in the ADR reporting policy and form, and ensure that these revisions address and correct all of the specific deficiencies that were outlined in this section of the baseline report. **Findings:** PSH has yet to implement this recommendation. **Recommendation 4, June 2007:** Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. **Findings:** PSH reviewed, aggregated and analyzed data regarding ADRs that were reported during the period of June 1, to October 31, 2007 (five months). The following is a summary of the results: 1. Twenty-one suspected ADRs were investigated compared to 51

		from the previous reporting period of December 2006 to April 2007 (six months). 2. All 21 ADRs were determined to be true reactions. 3. Nineteen ADRs were of probable causality and two were of possible causality. 4. One ADR was classified as severe (in June 2007) and required intensive case analysis; this contrasts with four cases requiring intensive case analysis in the previous reporting period (December 2006 to April 2007). This ADR was determined to be a case of acute pancreatitis possibly caused by divalproex. The reaction required hospitalization of the individual, who recovered. 5. Analysis of the remaining ADRs showed mild to moderate reactions, with divalproex being the most frequent offending agent. 6. Recommendations were made for all prescribers to review the DMH Psychotropic Medication Policy for divalproex, with special attention to monitoring items and consideration of tapering VPA in cases where it is being prescribed adjunctively for treatment of schizophrenia once symptoms have stabilized. **Other findings:** This monitor reviewed the intensive case analysis that was performed in June 2007 regarding an ADR of acute pancreatitis. This analysis included adequate review of the circumstances of the event and of possible contributing factors. However, the analysis did not include clear conclusions to address whether the individual had been properly monitored during the course of treatment (with divalproex) and the preventability of the reaction. In addition, the analysis did not include specific recommendations to address possible process deficiencies. **Compliance:** Partial.

		Current recommendations: 1. Increase reporting of ADRs. 2. Develop written instructions to all clinicians regarding significance and proper methods in reporting, investigating and analyzing ADRs. 3. Implement recent revisions in the ADR reporting policy. 4. Continue review and analysis of ADRs and present summary of aggregated data to address the following: a. The number of ADRs reported each month during the review period compared with number reported during the previous period. b. Classification of probability and severity of ADRs. c. Any negative outcomes for individuals who were involved in serious reactions. d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions. e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).
F.1.g	Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature. A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure that the DUE policy clearly codifies the requirement that the DUE schedule gives priority to high risk and high volume medication uses. **Findings:** The information provided by PSH did not address this recommendation in specific terms.

		Recommendation 2, June 2007: Consolidate the processes of DUE and MUE. All DUEs should include recommendations for corrective actions and there must be follow-up regarding these recommendations. **Findings:** PSH has implemented this recommendation. The MUEs have been consolidated into the DUE process. The DMH Psychotropic Guidelines require that DUEs include recommendations for corrective actions. All DUEs are reviewed in the P&T Committee and recommendations are distributed to appropriate disciplines and to the Medical Executive Committee for follow-up. **Recommendations 3-4, June 2007:** • Ensure that all DUEs include conclusions and recommendations for corrective actions regarding findings of deficiency, with follow-up by the medical staff and the P&T Committee, as appropriate. • Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. **Findings:** PSH presented a summary of all previously described data regarding medication monitoring. These data provide important information regarding the facility's compliance with indicators that align with requirements of the EP. However, the data did not include conclusions and recommendations to address patterns and trends. This information is required in a meaningful DUE. **Recommendation 5, June 2007:** Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.

		Findings: As mentioned in F.1.a., the DMH Statewide Psychopharmacology Committee has updated the guidelines. The facility has yet to conduct DUEs that can be used to inform further updates. **Compliance:** Partial. **Current recommendations:** 1. Ensure that the DUE policy clearly codifies the requirement that the DUE schedule gives priority to high-risk and high-volume medication uses. 2. Conduct DUEs that include review of the use, analysis of trends/patterns, conclusions regarding findings and recommendations for corrective actions/education activities based on the review. 3. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 4. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Develop and implement a data collection tool to assist staff in reporting potential and actual variances in all possible categories of variances. **Findings:** PSH has implemented this recommendation. The revised tool was approved in July and implemented in August 2007.

		Recommendation 2, June 2007: Provide instruction to all clinicians regarding the significance of and proper methods in MVR. **Findings:** The revised Nursing Policy and Procedure #511, Medication Variances (May 2007) includes adequate instructions. **Recommendation 3, June 2007:** Revise the current policy and procedure regarding MVR that includes a data collection tool. The procedure and the tool must correct the deficiencies identified above. **Findings:** PSH has updated its Nursing Policy and Procedure #511, Medication Variances (May 2007) and Pharmacy and Therapeutics Medication Variance Policy (September 2007) as well as AD #10.48, Medication Variances (November 2007). The updates contain information that adequately addresses the recommendation. However, the existence of two policies and procedures that address very similar and at times overlapping processes can impede the coordination of these processes and the interpretation of performance improvement needs of the facility. **Recommendation 4, June 2007:** Develop and implement adequate tracking log and data analysis systems to provide the basis for identification of patterns and trends related to medication variances. **Findings:** PSH reviewed, aggregated and analyzed the medication variances reported during the period of August to October 2007. The following is a summary of the results:

		1. The total numbers of variances were 149 (August), 315 (September) and 138 (October). 2. The total numbers of potential variances exceeded those of actual variances in each month. 3. Most of the variances were reported in the prescription category. 4. September data appeared to reflect improved compliance with reporting requirements. 5. None of the variances met criteria for serious outcome and, subsequently, no Intensive Case Analysis was required. 6. No negative clinical outcome was reported for any individual who was involved in these variances. **Recommendation 5, June 2007:** Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/ circumstances, preventability, contributing factors and recommendations. **Findings:** Based on the data presented by PSH, no Intensive Case Analysis was required during this review period. **Compliance:** Partial. **Current recommendations**: 1. Consolidate the facility's policies and procedures that address reporting of medication variances. 2. Develop written instructions to all clinicians regarding significance and proper methods in reporting, investigating and analyzing MVRs. 3. Continue review and analysis of medication variances and present summary of aggregated data to address the following:

		a. Total number of variances reported each month during the review period compared with numbers reported during the previous period; b. Classification of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual; c. Any negative outcomes for individuals who were involved in serious reactions; d. Data analysis regarding patterns and trends of variances, including recommendations for corrective actions; and e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).
F.1.i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Recommendation 2, June 2007:** Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use. **Findings:** PSH has yet to implement this recommendation. **Compliance:** Partial.

		Current recommendations: 1. Same as in F.1.a through F.1.h. 2. Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use.
F.1.j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: Same as above.
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as above. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: Same as above.

F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as in C.1.b., C.1.c., D.1.f.viii. and F.1.a. through F.1.h. **Findings:** Same as in C.1.b., C.1.c., D.1.f.viii. and F.1.a. through F.1.h. **Compliance:** Partial. **Current recommendations:** Same as in C.1.b., C.1.c., D.1.f.viii. and F.1.a. through F.1.h.
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	Please see sub-cells for compliance findings.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendations:** **Recommendation 1, April 2007:** Same as in F.1.c. **Findings:** Same as in F.1.c. **Recommendation 2, April 2007:** Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow- up actions by the Psychiatry Department. **Findings:** PSH has yet to implement this recommendation.

		Compliance: Partial. **Current recommendations:** 1. Same as in F.1.c. 2. Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow- up actions by the psychiatry department.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as above.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Same as F.1.e. **Findings:** Same as F.1.e. **Recommendations 2-3, June 2007:** • Ensure the proper identification and management of TD as well as proper frequency of clinical assessments. The management should include follow-up at a specialized movement disorders clinic run by a neurologist with relevant training and experience.

		• Ensure that the facility's monitoring data are based on a review of all individuals diagnosed with TD. **Findings:** Same as F.1.e. **Compliance:** Partial. **Current recommendations**: Same as F.1.e.
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, April 2007:** Same as in F.1.d. and F.1.g. **Findings:** Same as in F.1.d. and F.1.g. **Compliance:** Partial. **Current recommendations**: Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, April 2007:** Same as in C.2.o and F.1.c. **Findings:** Same as in C.2.o and F.1.c.

		Compliance: Partial. **Current recommendations**: Same as in C.2.o and F.1.c.
F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	

2. Psychological Services		
	Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:	**Methodology:** Interviewed: 1. Individuals TA, PS, LEF and MH 2. Allison Pate, PhD, Senior Supervising Psychologist 3. David Haimson, PhD, Chief of Psychology 4. Dominique Kinney, PhD, Psychologist 5. Don Brown, RN, PBS 6. Gari-Lyn Richardson, Standards Compliance Director 7. Georgiana Vinson, RN, Standards Compliance Auditor 8. Helga Thordarson, PhD, Senior Supervising Psychologist 9. Jacquelyn Williams, PhD, Psychologist 10. James Kelly, RT, BY CHOICE coordinator 11. Jeff Chambliss, PT, PBS 12. Jeffrey Weinstein, PhD, Psychologist 13. Joseph Malancharuvil, PhD, ABPP, Clinical Administrator 14. Maria Castillo, RN, PBS 15. Melanie Byde, PhD, Mall Director 16. Michelle Sefers, PT, PBS 17. Mona Mosk, PhD, psychologist 18. Susan Velasquez, PhD, Senior Supervising Psychologist Reviewed: 1. Charts of 33 individuals: AS, BA, CS, DE, DH, EJ, EM, GA, GB, GM, HHD, JB, JLO, JP, KD, KH, KK, LH, LMR, LQ, LT, ME, MHK, MT, NB, NL, OC, PSP, RA, RM, SC, ST, and TM 2. System-wide PBS Curriculum 3. List of PBS staff training documentation 4. List of Completed DSM-IV-TR Checklists 5. AD #15.09 (Positive Behavioral Support Program, October 22, 2007) 6. SO #129 (Positive Behavioral Support, January 26, 2007)

		7. AD #15.38 (BY CHOICE system) 8. AD #15.45 (Key Indicator/Trigger Reporting, April 1, 2007) 9. Staff Training in PBS implementation 10. PBS Plan Implementation Fidelity Checks 11. Nine Behavior Guidelines (GM, LH, AS, BA, EAJ, SC, KK, JB, and MT) 12. List of Individuals Needing Behavioral Interventions 13. PSH Psychologists' Guide to Behavioral Interventions 14. BY CHOICE Staff Development Training Report 15. PBS Monitoring Form 16. Six PBS Plans (RJ, HHD, EM, OC, DH, and GB) 17. DMH Psychology Services Monitoring Form 18. PSH Trigger Action Sheet Auditing form 19. List of Individuals Needing DCAT Services 20. BCC Meeting Minutes 21. List of Neuropsychological Focused Assessment Referrals 22. List of Treatment Groups Facilitated by Neuropsychology Consultation Services 23. Treatment Hours Provided by Neuropsychology Consultation Service 24. List of Individuals Who Received Cognitive Remediation 25. Psychology Newsletters ("Psychology Bugle" and The "EP Nutshell") <u>Observed</u>: 7. WRPC (Program VIII, unit 25) for BDM 8. WRPC (Program IV, unit 34) for DLG 9. WRPC (Program VI, unit EB-02) for AV 10. WRPC for JL 11. PSR Mall group: Smoking Cessation: You Can Quit 12. PSR Mall group: 64 Ways to Non-Violence (Program III, unit 31)
F.2.a	Each State hospital shall ensure that it has positive behavior support teams (with one team for	**Current findings on previous recommendations:**

	each 300 individuals), consisting of a clinical psychologist, a registered nurse, two psychiatric technicians (one of whom may be a behavior specialist), and a data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:	**Recommendations 1-3, June 2007:** • Complete revision of the PBS manual to include clear guidelines on the referral process (i.e., what triggers a referral, who is responsible for making the referral and what is expected once a referral is made, timelines). • Include in the PBS manual clear guidelines on how structural and functional assessments are to be performed. • Identify in the manual specific evidence-based tools to use for each type of assessment. **Findings:** PSH had delayed the completion of the revision of the PBS manual, in lieu of the system-wide PBS plan soon to be implemented at PSH. This system-wide plan has been developed by their DMH CRIPA consultant, Dr. Nirbhay Singh. This monitor reviewed the system-wide PBS curriculum. This is a well-developed plan, and when fully implemented will serve to establish a preventive/protective system, minimize the opportunity for maladaptive behaviors, and alert providers to develop and implement intervention plans as early as possible. PBS teams can be more effective under such a system-wide plan. The PSH Psychology Manual contains the regulation governing the development of structural and functional assessments. According to the Chief of Psychology, PBS psychologists always develop structural and/or functional assessments as part of the process of developing PBS plans. PBS team members have and continue to receive training on various aspects of PBS plans. The current PBS manual has identified specific evidence-based tools for the assessment of structural and functional assessments. **Recommendation 4, June 2007:** Recruit additional staff to meet the 1:300 ratios as required by the EP.

Findings:
PSH does not have the sufficient number of PBS team/members to meet the EP staff requirement ratio of 1:300. PSH has hired four nursing staff since the last court monitor review. Currently, PSH has two full teams and one team without a nurse team member. PSH does not have a DCAT team.

Recommendation 5, June 2007:
Train all direct care staff in PBS principles.

Findings:
PBS team members have actively conducted training of direct care staff in PBS principles. This monitor's review of PSH's staff training documentation showed that PSH has conducted a number of direct care staff training sessions. Newly hired staff is trained during New Employee Orientation.

The table below showing the number of employees needing training (N), the number of staff trained (T), and the Percentage of staff trained (%C) reporting 77% compliance, is a summary of the facility's data.

Employees trained from 5/2005-10/31/2007						
	MDs	PhDs & Trainees	SWs & RTs & Dieticians	RNs	PTs	Mean
N	97	66	151	471	713	
T	37	45	88	358	629	
%C	38	68	58	76	88	77

According to the Chief of Psychology, David Haimson, training of direct care staff was hampered due to a shortage of PBS team members. He expects training to go smoothly when additional PBS teams are hired and trained.

		Recommendation 6, June 2007: Ensure that the Chief of Psychology and the PBS coordinator are given the necessary clinical and administrative authority to carry out their tasks in order to improve the quality of life of individuals served in PSH. **Findings:** According to the Chief of Psychology and the PBS Chair, Susan Velasquez, they have the necessary clinical and administrative authority to carry out their tasks as delineated in their role and duties. This monitor reviewed the AD #15.09 (Positive Behavioral Support Program, October 22, 2007), and the SO #129 (Positive Behavioral Support, January 26, 2007). These documents provide the necessary authority to the Chief of Psychology and the PBS Chair. **Recommendation 7, June 2007:** Clarify and resolve differences found in the Administrative Directive (AD # 15.09) and Special Order (SO #129). **Findings:** PSH has aligned AD #15.09 with SO #129 as they relate to PBS. The revised documents were approved and implemented on October 22, 2007. **Compliance:** Partial. **Current recommendations:** 1. Implement the system-wide PBS plan. 2. Ensure that PSH has the required number of PBS teams by recruiting additional staff to meet the 1:300 ratio as required by the EP.

		3. Continue training of all direct care staff in PBS principles.
F.2.a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure that all relevant staff receives systematic training in all aspects of the PBS plans. **Findings:** PSH trains staff responsible for implementing PBS plans. PSH had three active PBS plans (ME, HD, and RJ) over the last six months. This monitor's review of the documents showed that staff responsible for implementing the plans was trained to competency, and certified before they implemented the plans. Training methods included oral presentation, written activities, and role-plays. **Recommendations 2-3, June 2007:** • Conduct treatment implementation fidelity checks regularly. • Develop a systematic way of evaluating treatment outcomes and reporting those outcomes. **Findings:** PSH conducts fidelity checks regularly on all active PBS plans. This monitor reviewed the documentation of the fidelity checks for three PBS plans (ME, RJ, and HD). Eight fidelity checks had been conducted for RJ, four for HD, and two for ME. PSH has identified the criteria for evaluation of treatment outcomes (items #22-25 of the DMH Positive Behavior Support Plan Monitoring Form), which include decreases in maladaptive behaviors, increases in replacement skills and/or alternative behaviors, achievement of broader goals, and durability of behavior change. According to the PBS Chair and the Chief of Psychology, PBS team members have not been

		using these criteria systematically, but rather have been evaluating the effectiveness by determining if the PBS plan goals were being met. The PBS Chair and the Chief of Psychology plan to use more systematic criteria to determine "if the PBS plan goals were being met." PBS teams may want to standardize the criteria for evaluating their outcomes/plans (for example, stability-same performance over 5 data points; improvement-20% improvement over baseline data, 50% reduction in seclusion/restraint over three weeks, etc.). Such standardization will automatically 'trigger' re-assessment of the plans, revision of objectives and interventions; and make documentation easier for WRPTs. According to the Chief of Psychology, the "PSH Psychologists' Guide to Behavioral Interventions" was distributed to all psychology staff, including fellows and interns. This monitor's review of this guide showed that it covers aspects of the PBS plan, behavior guidelines, PBS trigger reporting process, and the PBS-BCC Checklist procedures. PBS team leaders may want to coordinate this aspect of the recommendation with their CRIPA consultant, now that a system-wide PBS plan is being implemented. **Recommendations 4-5, June 2007** • Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs. • Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of level of care staff is necessary to improve treatment implementation. **Findings:** PSH used item #13 from the DMH Psychology Service Monitoring Form to address this recommendation, reporting 43% compliance. The table

below with its monitoring indicator showing the number of individuals with PBS plans who had WRPC's subsequent to the plan (N), number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

All PBS plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the Case Formulation in the individual's WRP.

	7/07	8/07	9/07	10/07	Mean
N	1	1	3	2	
n	1	1	3	2	
%S	100	100	100	100	
%C #13	0	100	67	50	43

This monitor review of the PBS plans and findings thereof was in agreement with the facility's data. The present status section of JR's WRP had good documentation on his PBS plan, even though the present status section as a whole was not comprehensive. Objective data was reported from the PBS plan showing percentage occurrence of target behaviors. HD'S WRP did not have any information on his PBS plan in the present status section, even though it was mentioned in the objective and intervention sections. The information in the objective section would have been more appropriate if it was included in the present status section. ME's WRP had a brief mention of his PBS plan in the present status section, and was also included in the objective and intervention sections.

PBS team members attend WRPCs of individuals with PBS plans and collaborate with WRPT members. Together, the WRPT members and the PBS team members review the individual's functioning, PBS plan data, and proper documentation of the plan in the present status, and the objective and intervention sections.

		This monitor observed PBS team members collaborating with WRPT members at a number of WRPCs (EG, BDM, AV, and EB). **Recommendation 6, June 2007:** The PBS teams, WRPTs and the BCC require better understanding of their interdisciplinary roles. **Findings:** This monitor's interview with the Chief of Psychology, PBS Chair, and review of BCC meeting minutes showed that PBS, BCC, and WRPT members are well informed about each other's roles and responsibilities. The Chief of Psychology is also the Chair of the BCC. PBS team members and unit staff are included in the BCC meetings. PBS team members participate in WRPCs. Furthermore, a formal training session on BCC's role was conducted on August 30, 2007. This monitor's review of AD #129.01 and AD #15.09 showed that BCC and PBS roles were explained in these documents. **Recommendation 7, June 2007:** Ensure that unit behavior guidelines are developed through data derived from structural and/or functional assessments. **Findings:** Unit psychologists are writing behavior guidelines, and in many cases with the support of PBS team members. PSH has written as many as 67 behavior guidelines in the last six months. The numbers of PBS plans are few owing in part to the timely development and implementation of behavior guidelines. Unit psychologists, in collaboration with PBS team members, are collecting data as part of their planning, development, and implementation of behavior guidelines. Their data collection is not extensive and the behavior guideline is primarily implemented in the residential unit. However, their plans showed that they are conducting

		"brief" structural and functional assessments through staff interviews and records review to derive an answer to the question, "Why does the behavior occur?" A full structural and functional assessment is not necessary for this purpose, which will be handled at the PBS level. This monitor discussed with the PBS team members how to structure and label sections of the behavior guideline to reflect the "brief" structural and functional assessments conducted as part of the data collection process in the development of behavior guidelines. PSH is to implement a system-wide PBS plan. PBS teams and unit psychologists should work with their CRIPA consultant on aligning their work with the system-wide PBS plan. **Recommendation 8, June 2007:** Develop a training protocol for all PBS plans to ensure that staff responsible for implementing the plans are appropriately trained (and certified) prior to implementation of the plans. **Findings:** This monitor reviewed the documentation addressing this recommendation. PSH has used the following steps in its training protocol: oral and written review of the PBS plan, modeling of the steps/procedures by the trainer/PBS team member, practice of these steps/procedures by the staff responsible for implementing the plan, certification of staff, and fidelity checks. **Recommendation 9, June 2007:** Integrate a response to triggers in the referral process. Ensure that appropriate and timely entry is made into the individual's WRP. **Findings:** PSH has implemented a hospital-wide trigger reporting system and trigger action process that is administered through the Standards

		Compliance department, in accordance with AD #15.45. The Chief of Psychology in collaboration with the PBS teams has developed a response to triggers. The PBS teams now receive (as of September, 2007) trigger data from Standards and Compliance. The PBS Chair assigned to the unit that houses an individual who triggers behaviorally alerts the unit psychologist concerned, and the PBS team works with the unit psychologist to determine the best course of action to manage the trigger. This monitor's review of the "Guide to Behavior Interventions" showed that the process of response to triggers is discussed in this guide. **Compliance:** Partial. **Current recommendations:** 1. Ensure that PBS psychologists have the authority to write orders for the implementation of PBS plans. 2. Ensure that all relevant staff receives systematic training in all aspects of the PBS plans. 3. Develop a systematic way of evaluating treatment outcomes and reporting those outcomes. 4. Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs.
F.2.a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Train all staff in correctly implementing the BY CHOICE program. **Findings:** PSH has actively conducted training of all staff on correctly implementing the BY CHOICE program. The table below shows the

number of staff trained from each category (T) and the percentage of staff trained in each category (%C).

	5/07	6/07	7/07	8/07	9/07	10/07	Mean
T/General Training	1794	1792	1795	1798	1801	1814	
%C	95	95	95	95	95	94	95
T/Data Entry Training	119	121	158	157	155	154	
%C	55	56	63	55	55	59	57
T/Point Allocation Training	38	39	50*	46	44	60	
%C	68	70	75	68	59	28	52
T/New Adm. Orientation	68*	46*	102	55	67	55	
%C	60	60	73	55	73	42	60

Recommendations 2-3, June 2007:

- Implement the program as per the manual.
- Ensure that the program receives adequate resources.

Findings:

PSH has implemented the BY CHOICE program to all units in the facility. The program continues to have resource needs including a computer inventory system for the Incentive Stores.

Recommendations 4-6, June 2007:

- Ensure that the individuals have the final choice in allocating points per cycle, ranging from 0 to 100 per cycle.
- Report BY CHOICE point allocation in the present status section of

the individual's case formation and update at every scheduled WRPC.

- Ensure that individuals know the performance requirements to earn full points.

Findings:

PSH used item #6C from the DMH WRP Observation Monitoring Form to determine BY CHOICE point allocation discussion with the individual, reporting 5% compliance. The table below with its monitoring indicator showing the number of WRPCs due each month (N), the number of WRPC observed by Standards and Compliance (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

The WRPT reviews the BY CHOICE points, preferences and allocation with the individual.

	5/07	6/07	7/07	8/07	9/07	10/07	Mean
N	985	937	1040	1035	887	1001	
n	186	164	198	193	95	162	
%S	19	18	19	19	11	16	
%C #6C	0	2	8	12	1	2	5

PSH used item #6D from the DMH WRP Observation Monitoring Form to address this recommendation, reporting 4% compliance. The table below with its monitoring indicator showing the number of WRPCs due each month (N), the number of WRPCs observed by Standards and Compliance (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

The individual determines how he or she will allocate the points between WPRCs.

	5/07	6/07	7/07	8/07	9/07	10/07	Mean
N	985	937	1040	1035	887	1001	
n	186	164	198	193	95	162	
%S	19	18	19	19	11	16	
%C #6D	0	2	7	10	0	1	4

PSH used item #16 from the DMH Psychology Services Monitoring Form to determine the extent to which BY CHOICE point allocation is updated in the WRP, reporting 11% compliance. The table below with its monitoring indicator showing the average daily census of individuals in the facility (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

The BY CHOICE point allocation is updated monthly in the individual's WRP.

	5/07	6/07	7/07	8/07	9/07	10/07	Mean
N	1499	1499	1498	1505	1499	1504	
n	52	46	26	14	185	165	
%S	3	3	2	1	12	11	
%C #16	12	11	8	21	11	13	11

PSH used item #B4 from the BY CHOICE Competency and Fidelity Survey to determine if the individuals know what they had to do to earn different levels of BY CHOICE for their participation in various activities, reporting 93% compliance. The table below with its monitoring indicator showing the average daily census (N), the number of individuals surveyed by Standards and Compliance (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

The individuals can discuss to the best of their ability what the expectations are for them to earn FP, MP, and NP for the current cycle.

	5/07	6/07	7/07	8/07	9/07	10/07	Mean
N	1499	-	1498	1505	1499	1504	
n	16	-	20	43	66	66	
%S	1	-	1	3	4	4	
%C #B4	50	-	95	95	97	97	93

Data in the tables above show that PSH does not address aspects of the BY CHOICE program properly. This monitor's chart review and observation of WRPCs support PSH's self-evaluation data, as discussed below.

Individuals interviewed by this monitor indicated that they are aware that they have control over their point allocation. A number of them reported that they receive full points, for the most part, for just showing up to their Mall groups.

Documentation of an individuals BY CHOICE point allocation is poor. For example, this monitor reviewed nine charts (PSP, LQ, JLO, NL, MHK, NB, EJ, RA, and KH). Except for one (KH), the point allocations in eight of them (PSP, LQ, JLO, NL, MHK, NB, EJ, and RA) were unsatisfactory. Most of them made superficial mention of the individual's BY CHOICE point allocation (PSP, JLO, NL, MHK, and LQ), had no mention of the individual's BY CHOICE program (RA), was not individualized (NB), or use the boiler-plate statement repeatedly (EJ, " "…individual wants catalogue to choose items", found in more than one WRP).

		Compliance: Partial. **Current recommendations**: 1. Train all staff in correctly implementing the BY CHOICE program. 2. Ensure that the program receives adequate resources. 3. Report BY CHOICE point allocation in the present status section of the individual's case formation and update at every scheduled WRPC. 4. Ensure that individuals know their performance requirements to earn full points.
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	**Current findings on previous recommendation:** **Recommendations 1-2, June 2007:** • Implement the AD. • Follow the requirements of the EP. **Findings:** According to the Chief of Psychology, David Haimson, he has the clinical and administrative authority for the Positive Behavior Supports team and the clinical but not full administrative authority for the BY CHOICE incentive program. This monitor's review of the relevant Administrative Directives (AD #15.38, BY CHOICE; and AD #15.09, PBS) showed that the regulations were included in them. **Compliance:** Substantial. **Current recommendations**: Continue current practices.

F.2.c	Each State Hospital shall ensure that:	**Compliance:** Partial.
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure staff is fully trained in structural and functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. **Findings:** PSH has continued to provide training to its PBS staff. PBS staff attended training sessions led by their CRIPA consultant, Dr. Nirbhay Singh, on December 13 and 14, 2006; and January 9 and 10, 2007 and by Angela Adkins, another of their consultants, on July 31 and August 1, 2007. This monitor met with the PBS staff. They were much more confident and evidenced increased knowledge and understanding on PBS principles and procedures when compared with the meeting this monitor had with them at the previous review. **Recommendations 2-3, June 2007:** • Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. • Use the PBS-BCC pathway for all consultations. **Findings:** PSH has decided to use the Integrated Psychological Assessment, triggers, and review of individuals with Foci 1 and 3, as a means of identifying individuals who are in need of behavioral interventions. According to the Chief of Psychology, once an individual is identified as needing behavioral interventions, unit psychologists evaluate the individual to determine the most appropriate type of intervention. Intervention plans are subsequently developed and implemented in

		collaboration with the individual's WRPT. This monitor reviewed the list of individuals needing behavioral interventions. A breakdown of the list showed a total of 771 individuals with Focus 1 (aggression, 470; self-injurious behavior, 202; property destruction, 20; non-adherence to medication, 83; non-adherence to treatment, 124), and 440 with Focus 3. According to Susan Velasquez, Senior Supervising Psychologist, the list was compiled from auditing all WRPCs over the last six months, resulting in 780 individuals (52%) identified as needing behavioral interventions. PSH continues to emphasize the PBS-BCC as a pathway for all consultations, and requires that a PBS-BCC checklist is completed when referrals/consultations are requested. PSH should align its practices and procedures regarding referrals and interventions with the system-wide PBS plan. **Current recommendations**: Continue current practice of staff training on PBS principles and practices.
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Ensure that proper assessments are conducted prior to developing and implementing intervention plans. • Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation. **Findings:** PSH used item #1-12 from the DMH PBS Plan Monitoring Form to

evaluate compliance for all PBS plans. The items audited with their corresponding mean percentages are presented below (This monitor modified the items for brevity).

1.	*The individual's Wellness and Recovery Plan (WRP) Team and other relevant personnel are involved in the assessment and intervention process*	67%
2.	*Broad goals of intervention were determined*	100%
3.	*At least one specific behavior of concern was defined in clear, observable and measurable terms*	100%
4.	*Baseline estimate of the maladaptive behavior was established in terms of objective measures*	100%
5.	*Pertinent records were reviewed*	100%
6.	*Structural assessments were conducted, as needed, to determine broader variables affecting the individual's behavior*	100%
7.	*Functional assessment interviews were conducted with people who often interact with the individual within different settings and activities*	78%
8.	*Direct observations were conducted across relevant circumstances as appropriate*	44%
9.	*Other assessment tools were used to produce objective information regarding events preceding and following the behavior of concern, as well as ecological and motivational variables that may be affecting the individual's behavior*	56%
10.	*Patterns were identified from the data collected that included (1) circumstances in which the behavior was most and least likely to occur, and (2) specific functions the behavior appeared to serve for the individual*	100%
11.	*Broader variables that may be affecting the individual's behavior were identified*	67%

		12. *Patterns were summarized into written hypotheses based on structural and/or functional assessments* — 78% This monitor's review of the PBS plans (RJ, HD, EM, OC, DH, and GB) and findings is in agreement with PSH's data. **Current recommendations**: 1. Ensure that proper assessments are conducted prior to developing and implementing intervention plans. 2. Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.
F.2.c.iii	There is documentation of previous behavioral interventions and their effects;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Document previous behavioral interventions and their effectiveness. **Findings:** According to the Chief of Psychology, Senior Supervising Psychologists, and the PBS Chairs, PBS plans/behavioral interventions at PSH document previous behavioral interventions and their effectiveness, if such data is available. All structural/functional assessments reviewed by this monitor (LMR, ME, LT, ST, HD, GA, DE, CS, KD, RM, and TM) had documentation of the individual's previous treatment history and their effectiveness (medical and/or behavioral). **Current recommendations**: Continue current practice.

F.2.c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Ensure that all behavioral interventions are based on a PBS model without any use of aversive or punishment contingencies. • Ensure that all available support systems within PSH, including PBS, BCC, Recovery Encouragement Group, PSR Mall groups, BY CHOICE, and individual therapies to address individuals' maladaptive behaviors, use positive contingencies. **Findings:** PSH audited the PBS plans developed during the last six months using item #17 (*The PBS plan includes strategies for managing consequences so that reinforcement is i) maximized for positive behavior, and ii) minimized for behavior concern, without the use of aversive or punishment contingencies*) from the DMH Psychology Services Monitoring Form to address this recommendation, reporting 100% compliance. PSH also audited 36 behavior guidelines (54% of all behavior guidelines written) using item #8 (*Behavioral interventions, which include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies*) from the DMH Psychology Services Monitoring Form to address this recommendation, reporting 92% compliance. According to the Chief of Psychology, PSH adheres to the principle and philosophy of a positive model of service. PBS team members reported to this monitor that they have never incorporated any negative/ punishment procedures in their PBS plans. However, four recently developed behavior guidelines (KK, JP, JB, and SC) contained elements of aversive components. For example, KK's behavior guideline had included "threats of PRN and restraint". Interestingly, the behavior

		guideline continues to state that "although threatening her with PRN medication is not permissible, reminding her of the negative consequences of her violent behavior is permitted." This behavior guideline also includes other statements that are unclear. For example, a statement reads "…reward her appropriate behavior. Her appropriate behavior must be functional and rewarding for it to continue." This statement raises questions such as if "appropriate," why other conditions? How is "functional" to be determined? And "rewarding" for who? Such plans will confuse the individual and make consistent implementation across providers difficult. The Senior Psychologists promptly identified these plans, during their monthly reviews, and discussed the plans with the staff concerned. According to the Chief of Psychology, these behavior guidelines were developed by a newly employed staff member. Senior Psychologists have planned to continue with training on positive approaches to interventions. The Psychology Department has put out a number of newsletters that regularly give feedback to staff on matters pertaining to the EP. This monitor's review of two sample newsletters (The "Psychology Bugle" and The "EP Nutshell") showed that the newsletters included information on EP requirements. A number of documents reviewed by this monitor contained statements attesting to PSH's philosophy to the adherence of a positive approach. These documents include AD #15.09 (PBS), AD #15.38 (BY CHOICE), and the PBS and the BY CHOICE Manuals. PSH is implementing a system-wide PBS plan. This system-wide PBS curriculum using positive approaches was developed by their DMH CRIPA Consultant, Dr. Nirbhay Singh. **Current recommendations**: Ensure that all behavioral interventions are based on a PBS model without any use of aversive or punishment contingencies.

F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	**Current findings on previous recommendations:** **Recommendations 1-4, June 2007:** • Ensure that staff across settings is aware of individuals' behavioral plans and that they receive written plans and training. • Ensure that all behavioral interventions are consistently implemented across all settings, including the PSR mall and vocational and education settings. • Conduct training across settings so that staff in those settings has the knowledge and skill to implement interventions for individuals who are on such plans. • Conduct regular fidelity checks. **Findings:** PSH audited all active PBS plans using Item #20 (*Everyone working with the individual on a regular basis is familiar with the PBS plan and implements its strategies with high degree of fidelity*) from the DHM PBS Monitoring Form to address this recommendation, reporting 67% compliance. This monitor's review of active PBS plans (JR, HD, and ME) and behavior guidelines (GM, LH, AS, BA, and MT) showed that staff training was conducted prior to implementing the plans. Behavioral guidelines were developed with support from PBS team members. PBS plans were implemented in settings where the maladaptive behaviors were evidenced, whereas behavioral guidelines were implemented in the residential units. Behavioral interventions were not implemented consistently within and across settings. Fidelity checks were conducted on all PBS plans. This monitor's interview of Mall course facilitators showed that the facilitators were aware of the individual's PBS plans. However, the facilitators were not familiar with the elements of the PBS plans because they did not have the occasion to

		implement the plan since the maladaptive behavior in question was not evidenced in that setting. **Current recommendations**: 1. Ensure that staff across settings is aware of individuals' behavioral plans and that they receive written plans and training. 2. Monitor the implementation of PBS plans to ensure that all behavioral interventions are consistently implemented across all settings, including the PSR Mall and vocational and education settings. 3. Conduct training across settings so that staff in those settings has the knowledge and skill to implement interventions for individuals who are on such plans. 4. Conduct regular fidelity checks.
F.2.c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;	**Current findings on previous recommendation:** **Recommendations 1-4, June 2007:** • Ensure that staff understands the nature and function of triggers. • Refine the implementation of the trigger system. • Ensure that individuals with maladaptive behaviors receive appropriate structural and/or functional assessment followed by proper treatment plans to address the behaviors. • Ensure proper documentation. **Findings:** According to Gari-Lyn Richardson, Director of Standards Compliance, PSH has conducted training with the Medical Staff, Program Directors, and Clinical Staff on the trigger systems. The staff is also required to read and sign the "Key Indicator and Trigger Reporting" sheets (as required by AD #15.45). This monitor's interview of Psychology staff, PBS team members, and WRPT members showed that they were aware of triggers and to whom they should be addressing the issue.

		The Chief of Psychology and the PBS Chairs receive the trigger data. Unit psychologists assigned to the unit where the trigger occurred are informed about the trigger. Together with the PBS team, the unit psychologist evaluates the individual, and a determination is made on the best treatment/therapy approach to deal with the individuals' maladaptive behaviors. All PBS plans reviewed by this monitor (RJ, HD, and ME) included appropriate assessment procedures, including structural and functional assessments. These plans were documented in the individuals' WRPs, though the documentation in most cases was unsatisfactory. This monitor expects PBS documentation in WRPs to improve now that PBS team members attend WRPCs and collaborated with WRPTs, as was observed by this monitor (AV, EG, and BDM). **Current recommendations**: 1. Refine the implementation of the trigger system. 2. Ensure proper documentation.
F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment options. Ensure that treatment modalities are integrated to better serve individuals, as indicated. **Findings:** All PBS plans reviewed by this monitor (RJ, ME, and HD) had structural/functional assessments, conducted as part of their overall assessments in the development of the PBS plans.

		PSH audited PBS plans using item #11 (*PBS teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy*) from the DMH Psychology Services Monitoring Form to address this recommendation, reporting 0% compliance. This monitor reviewed a number of structural and functional assessments of PBS plans (LMR, CS, TM, MAE, DE, and HD). In all cases, the staff had looked into the individual's medication history, psychiatric history, and included graphs showing the medications taken and occurrences of target behaviors. Furthermore, in a few cases it was hypothesized that the function of the target behaviors might be due to medication/emotional dysregulation. In most cases there was no follow-up to further delineate this hypothesis through consultation with the psychiatrist/nurse practitioner. In the case of LMR, the psychologist had consulted the team psychiatrist (progress note, November 21, 2007); even in this case there was no follow-up to evaluate if the change in medication delivery (via IM) influenced the rate of target behaviors. In the case of TM, the psychologists ruled out the "relationship between behaviors and medication." No multimodal consideration was evident in the other cases, even when there was evidence for such consideration. For example, CS's physical aggression was observed to have increased significantly during the times when CS refused to take his medications, but this was not followed up with any consultation with the medical staff. **Current recommendations**: Ensure that treatment modalities are integrated to better serve individuals, as indicated.
F.2.c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and	**Current findings on previous recommendation:** **Recommendation 1, June 2007:**

Recovery Plan;

Specify PBS plans in the objectives and interventions sections of the individual's WRP, as outlined in the DMH WRP Manual.

Findings:
PSH used item #12 from the DMH Psychology Services Monitoring form to address this recommendation, reporting 67% compliance. The table below showing the monitoring indicator, the number of PBS plans in implementation (N), the number of PBS plans audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

The PBS plan is clearly specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan.

	7/07	8/07	9/07	10/07	Mean
N	2	3	4	3	
n	2	3	4	3	
%S	100	100	100	100	
%C #12	50	67	50	100	67

This monitors review findings of the same PBS plans reviewed by PSH are in agreement with the facility's data.

Recommendation 2, June 2007:
Ensure that WRPTs use the DMH WRP Manual.

Findings:
This monitor reviewed the staff development documentation. PSH had conducted training sessions with psychologists, social workers, and rehabilitation therapists on WRP and WRPC procedures. According to the Chief of Psychology, the DMH WRP manual was distributed to all unit psychologists. Unit psychologists now guide the WRPTs on conference procedures as required indicated in the DMH WRP manual.

		However, as shown by the data presented in the various sections of this report, WRPC procedures and documentation in WRPs is still poor. **Recommendation 3, June 2007:** PBS senior psychologists may need to attend the individual's first WRPC once a PBS plan has been implemented, to make certain this requirement is met. In addition, this will give an opportunity for the PBS team member to provide training and/or information to the individual's WRPT. **Findings:** According to the Chief of Psychology, PBS team members attend the first and subsequent WRPCs of individuals with a PBS plan. The PBS team members, when possible, also attend WRPCs on individuals with behavior guidelines. PBS team members were present and participated in many of the WRPCs observed by this monitor. **Current recommendations**: Specify PBS plans in the objectives and interventions sections of the individual's WRP, as outlined in the DMH WRP Manual.
F.2.c.ix	all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan	**Current findings on previous recommendation:** **Recommendations 1-3, June 2007:** • Ensure that all PBS plans are updated using outcome data in the individual's present status section of the WRP. • Ensure that necessary assessments and PBS plans are filed in the individual's chart. • Ensure that assessments and PBS plans are not purged from the charts when the charts are "thinned." **Findings:** This monitor's review of three charts (RJ, HD, and ME) involving

		individuals with PBS plans showed that the PBS plans were documented in the present status section of the WRP's for RJ and EM, but not for HHD. The PBS plans themselves were present in the "Current Treatment Plan" section of the charts. Documentation and updates of PBS plans in the individuals' WRPs has improved with the participation of PBS team members in WRPCs. According to the Chief of Psychology, removal of PBS plans from the charts ("thinning") was addressed through meetings with the Medical Records Committee (attended by Susan Velasquez, PBS Chair, in September and October 2007). According to the Chief of Psychology, the PBS form for purging has been approved to the "do not purge/thin" forms list and was approved at the Medical Records meeting (October 24, 2007). **Current recommendations**: 1. Collect objective information to evaluate the effectiveness of the PBS plans, including change in behaviors, stability of behavior change, changes in co-varying behaviors, achievement of broader goals and durability of behavior change. 2. Continue to track and monitor that PBS plans are updated using outcome data in the individual's present status section of the WRP.
F.2.c.x	all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.	**Current findings on previous recommendations:** **Recommendations 1-3, June 2007:** • Provide competency-based PBS training to all staff. • Ensure that performance improvement measures are in place for monitoring the implementation of such interventions. • Ensure that PBS plans are fully implemented once the plans are "tested" in the unit by the PBS team and the unit staff is trained.

		Findings: This monitor's document review and staff interview showed that PBS uses structured steps (receiving referral through the PBS-BCC checklist, conducting appropriate assessments, developing and implementing the plan, training unit staff to competency to implement the plan, conducting fidelity checks regularly, revising the plans when indicated, or referring the case to BCC if there is no improvement). Performance improvement measures are addressed through the steps outlined in the PBS plan. This monitor's review of PSH's PBS plans (RJ, HD, ME, and GB) was consistent with the process used by PSH. However, emphasis should be given by PBS teams to ensure that implementation of the plans is consistent across settings (in all settings where the behaviors are evidenced) and that assessment and treatment includes collaboration with other disciplines (where indicated). **Current recommendations**: 1. Provide competency-based PBS training to all staff. 2. Ensure that PBS plans are fully implemented once the plans are 'tested' in the unit by the PBS team and the unit staff is trained.
F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Ensure required number of PBS teams to meet the 1:300 ratios. **Findings:** PSH does not have the required number of PBS teams to meet the 1:300 ratios. PSH has two full PBS teams, and one without a nursing team member. PSH is actively recruiting to fill the vacant positions. PSH is implementing a system-wide PBS program, developed by their

		CRIPA consultant. Additional PBS teams may become necessary for the system-wide program to be fully functional. **Current recommendations**: Ensure required number of PBS teams to meet the 1:300 ratios.
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP. **Findings:** PSH's BY CHOICE point allocation documentation is poor. The BY CHOICE coordinator, James Kelly, has provided training to WRP staff and prepared sample documentation guides to assist WRPTs. However, implementation of this task continues to be poor. For example, PSH's audit of this recommendation using item #16 (*The BY CHOICE point allocation is updated monthly in the individual's WRP*) found that only 11% of the WRPs audited had proper documentation. This monitor's review of WRPs showed a similar pattern of poor documentation. For example, of the nine charts reviewed by this monitor (PSP, LQ, JLO, NL, MHK, NB, EJ, RA, and KH), only one (KH) had a reasonable/acceptable documentation of the individual's BY CHOICE point allocation. **Current recommendations**: Ensure that BY CHOICE point allocation is updated monthly in the individual's WRP.
F.2.d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team	**Current findings on previous recommendations:**

	(DCAT; consisting of a clinical psychologist, a registered nurse, a social worker, a psychiatric technician, and a data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.	**Recommendation 1, June 2007:** Develop and implement a full DCAT, consisting of a clinical psychologist, registered nurse, social worker, psychiatric technician and data analyst. **Findings:** PSH does not have a DCAT at this time. PSH is in receipt of the statewide DCAT manual. PSH has identified individuals needing DCAT services. The list was drawn from those with Mental Retardation and other Axis III diagnoses (head trauma, Dementia, Borderline Intellectual Functioning, Seizure Disorders, history of traumatic brain injury). This monitor's review of PSH data showed that 237 individuals met criteria. Service to these individuals is further hampered because all other branches of the Psychology Department also experience staffing shortage (PBS, Neuropsychology, Psychology Assessment teams). Some of the individuals are assessed and served through the Neuropsychology Consultation Service. **Compliance:** Partial. **Current recommendations:** 1. Develop and implement a full DCAT, consisting of a clinical psychologist, registered nurse, social worker, psychiatric technician, and data analyst. 2. Ensure that all individuals with cognitive challenges are assessed by the DCAT. 3. Ensure that all DCAT members are available for consultation to other staff to assist with planning therapeutic activities at the individual's cognitive functioning level. 4. Ensure that DCAT members' primary responsibility is consistent with the EP. 5. Ensure that DCAT members receive appropriate training.

F.2.e	Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.	**Current findings on previous recommendations:** **Recommendations 1-5, June 2007:** • Ensure that the BCC functions as intended by the EP. • Ensure that staff is informed regarding the sequence of steps for referrals to the BCC (PBS-BCC checklist). • Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly. • Include PBS team members and WRPT members at BCC team meetings. • Set up a system of accountability to ensure that BCC recommendations are implemented. **Findings:** This monitor's interview with the Chair of the Behavioral Consultation Committee, David Haimson, who is also the Chief of Psychology, and review of documentation showed that BCC is functioning as required by the EP. The BCC provides support to the PBS teams, reviews triggers, reviews cases that show lack of/slow progress, and conducts regularly scheduled meetings. It was also apparent from interview of PBS and WRPT staff that they are aware of the PBS-BCC referral process. All referrals now come with a completed PBS-BCC checklist. This monitor's review of the BCC meeting minutes showed that BCC had held five meetings since July 2007, and most of these meetings were well attended. The minutes also showed that PBS team members and unit staff involved in the care of the individual were at the meetings. According to the BCC chair, there is no system in place to ensure that BCC plans were being implemented consistently. It is this monitor's view that the task is best delegated to the PBS teams. Most of the BCC plans, if not all, originate from PBS plans; in addition, PBS teams are collaborating with unit staff on behavior guidelines. As such, PBS

		teams monitoring implementation of the BCC plans will give continuity of data collection and monitoring. Obviously, this is not a task the PBS teams can handle without additional teams. **Compliance:** Substantial. **Current recommendations**: 1. Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly. 2. Set up a system of accountability to ensure that BCC recommendations are implemented.
F.2.f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.	**Current findings on previous recommendation:** **Recommendations 1-3, June 2007:** • Ensure that WRPT members, especially psychiatrists and psychologists, make referrals, when appropriate, for neuropsychological assessments. • Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall. • Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services. **Findings:** PSH determined that in the last six months, 7% of the individuals in need of Neuropsychological Focused Assessments (NFA) were referred for assessments. This percentage was derived from an expected referral of 45%, based on the RBANS screening index score. According to the Neuropsychology staff PSH does not have sufficient Neuropsychology staff to screen all admissions and/or track individuals in need of Neuropsychological assessments.

The Neuropsychology Consultation Service conducted training sessions with the staff to improve their knowledge and understanding of Neuropsychology referrals. The first training session titled "Symptom Recognition and Differential Diagnosis of Brain Encephalopathy," was presented to the Medical Staff on August 15, 2007; the second training session titled "Neurocognitive Screening in a Psychiatric Setting: An Update," was presented to the Psychology staff on August 29, 2007; and the third training session titled "Psychiatric Neuropsychology in a Forensic Setting," was presented on September 26, 2007 to all treatment team members. (According to the Chief of Psychology, this session was telecast to all DMH hospitals).

Recommendation 2, June 2007:
Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR mall.

Findings:
This monitor's review of the documentation showed that a total of 74 individuals had received cognitive remediation/retraining through the Neuropsychological Consultation Service over the nearly 12 months. The table below showing the number of individuals in need of cognitive remediation/retraining (N), the number of individuals who received cognitive remediation/retraining (T), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	5/07	6/07	7/07	8/07	9/07	10/07	Mean
N	676	673	678	678	675	677	
T	34	34	28	28	28	39	
%C	5	5	4	4	4	6	4.6

The cognitive remediation/ retraining was conducted by three Neuro-psychologists and a Post-Doctoral Neuropsychology Fellow. This monitor's review of the Mall hours scheduled and provided showed that

these staff provided an average of 12 hours of Mall services per week. This is twice the hours of services provided by the Neuropsychology Consultation Service at the July 2007 review.

Recommendation 3, June 2007:
Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.

Findings:
PSH has three Neuropsychologists on its roster. This number is insufficient to provide all the necessary assessments and treatment services to all individuals in the facility, especially if an increase in referrals were to be received owing to the staff training conducted by the Neuropsychology Consultation Services.

Recommendation 3, June 2007:
Ensure that retesting and follow-up neuropsychological evaluations are conducted in a timely fashion.

Findings:
PSH is unable to conduct its retesting and follow-up neuropsychological evaluations in a timely fashion. The table below showing the number of Neuropsychology referrals received each month (N), the number of assessments conducted within 60 days of referral (n), and percentage of assessments completed within the time period (%C), reporting 67% compliance, is a summary of the facility's data.

	5/07	6/07	7/07	8/07	9/07	10/07	Mean
N	9	6	8	12	8	7	
n	9	6	8	12	8	7	
%S	100	100	100	100	100	100	
%C	67	67	50	75	75	43	67

		As the data in the table show, only 67% of all referrals were assessed in a timely manner. This monitor's review of available documentation showed that as many as 11 referrals were still to be completed at the time of this tour. This situation further highlights the need for increase in the number of Neuropsychologists at PSH. **Compliance:** Partial. **Current recommendations**: 1. Ensure that WRPT members, especially psychiatrists and psychologists, make referrals, when appropriate, for neuropsychological assessments. 2. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services. 3. Ensure that retesting and follow-up neuropsychological evaluations are conducted in a timely fashion.
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • The hospital and/or state must provide psychologists the authority to write orders as specified in the EP. • Ensure that this authority is fully approved and implemented. **Findings:** PSH has approved the authority for psychologists in its facility to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates. The authority is reflected in AD #15.09 (October 22, 2007). The authority is yet to be included in the Nursing Policy manual. According to the PBS coordinator and the Chief of Psychology, the Nursing coordinator has accepted the AD and is looking

		into making the necessary changes in the Nursing Policy manual. **Compliance:** Partial. **Current recommendations:** Ensure that this authority is fully approved and implemented.

3. Nursing Services		
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	**Methodology:** Interviewed: 1. Regina Olender, Nurse Administrator 2. Gari-Lyn Richardson, RN, Director of Standards Compliance 3. Valerie Pollard, Nursing Performance Improvement Coordinator 4. Tatiana Rojas, RN, Standards Auditor 5. Dorice Gonzalez, Unit Supervisor 6. Richard Rose, Unit Supervisor 7. Gabriel Hernandez, Unit Supervisor 8. Scott Starbuck, Unit Supervisor 9. Ginny Gibialante, Program Director 10. Jack Kennedy, Acting Recovery Coordinator for Program IV 11. Peggy Thomas, Program Director for Program VII Reviewed: 1. Staff Development training reports 2. Change of Shift Report Program IV computer report 3. Change of Shift Project agenda dated 9/10/07 4. PSH Enhancement Plan of Action Tracking Sheet for Nursing 5. Revised DMH Nursing Services Monitoring Form and instructions (11/07) 6. Memo dated 6/21/07 to all nursing staff regarding PRN and Stat Medication 7. In-Service agenda for Stat and PRN Medication Enhancement Plan Requirements 8. PRN and Stat Medication Competency Evaluation data 9. NP 511, Medication Variances 10. NP 302, Nursing Application of the Wellness and Recovery Plan 11. NP xiii, Nursing Services and The Recovery Philosophy 12. NP 303, Recovery Focused Documentation 13. NP 538, PRN and Stat Medication

		14. AD 15.14, Seclusion and Restraint 15. A Star Among Us Project 16. Registry Training Agenda for August 21, 2007 17. Memo dated 8/22/07 to all nursing staff regarding Nursing Services Documentation 18. PSH Wellness and Recovery Psychiatric Mental Health Nursing Training lesson plan 19. New Employee Orientation sign-in sheets 20. PSH progress report and data 21. Medical records for the following 47 individuals: GM, JH, JM, DR, DD, HE, RG, ML, WS, MB, GP, DA, OC, KK, DM, TB, GD, CR, JK, HMD, KMH, TEM, JGR, KS, RR, TT, JS, AB, MJ, RC, AC, KC, EYB, RA, MC, PT, CW, JCP, JCS, MAS, SLT, FGP, TMA, PRM, WPW, JT, and HR <u>Observed</u>: 1. Shift report for Unit EB-09
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	**Compliance:** Partial.
F.3.a.i	safe administration of PRN medications and Stat medications;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue to develop and implement policies and procedures that ensure the safe administration of PRN medications and Stat medications.

		Findings: NP 538, PRN and Stat Medication adequately addresses this recommendation. **Recommendation 2, June 2007:** Ensure there is a reliable system for tracking and reporting PRN and Stat medications. **Findings:** The statewide Nursing Services group met at MSH 10/30-31/2007 to clarify and refine the monitoring tools and instructions. In addition, the PLATO system is now being used for inputting data to ensure reliability. Also, additional auditors have been hired and are being trained on the PLATO system. After the training is completed, the facility will then implement inter-rater reliability. **Recommendation 3, June 2007:** Develop and implement definitions that adequately identify PRN and Stat medications. **Findings:** The definitions for PRN and Stat medications have been adequately developed and are the same for the trigger system. Also, AD 15.14, Seclusion and Restraint and NP 538, PRN and Stat Medication include adequate definitions of PRN and Stat medications. **Recommendation 4, June 2007:** Continue to monitor the administration and documentation of medication administration, including PRN and Stat medications. **Findings:** The data from the DMH Nursing Administration of PRNs audit for July-October 2007, based on a mean audited sample of 3%, indicated:

There was a complete physician's order written for the PRN medication	97%
The nursing staff checked the individual's chart for allergies	65%
The Medication Treatment Record (MTR) or Interdisciplinary Note (IDN) checked and interpreted the individual's vital signs and notified a physician if needed prior to administration of the medication	95%
The nursing staff administered the correct medication, dose, route, on the correct date and time to the correct individual	97%
The nursing staff who administered the medication attended the medication class within the last 12 months	94%

The data from the DMH Nursing Administration of Stats audit for August-October 2007, based on a mean audited sample size of 26%, indicated:

There was a complete physician's order written for the Stat medication	97%
The nursing staff checked the individual's chart for allergies	97%
The Medication Treatment Record (MTR) or Interdisciplinary Note (IDN) checked and interpreted the individual's vital signs and notified a physician if needed prior to administration of the medication	97%
The nursing staff administered the correct medication, dose, route, on the correct date and time to the correct individual	97%
The nursing staff who administered the medication attended the medication class within the last 12 months	No data provided

		Data provided by PSH for both PRN and Stat medications included an item regarding "nursing staff safely administers PRN/STAT medications," which could not be interpreted. The facility indicated that data for May and June for the PRN audit and May, June and July for the Stat audit could not be accurately reported since PLATO inputting had not been implemented during these months. **Recommendation 5, June 2007:** Ensure staff competency regarding deficiencies and appropriate procedures for safe administration of PRN medications and Stat medications. **Findings:** Compliance with competency regarding PRN medications was included in PSH data (94%). However, there was no compliance data reported for Stat medications. **Recommendation 6, June 2007:** Continue to monitor this requirement. **Findings:** Same as above under Recommendation 4. **Current recommendations**: 1. Report compliance with competency for Stat medications. 2. Increase sample size audited for PRN medications. 3. Continue to monitor this requirement.
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Develop and implement a system to ensure the reliability of the data.

Findings:
See F.3.a.i.

Recommendation 2, June 2007:
Continue to provide staff training on policy and procedure revisions.

Findings:
PSH has trained 85% of staff regarding this recommendation as of 11/13/07, as supported by review of the training rosters.

Recommendation 3, June 2007:
Continue to monitor this requirement.

Findings:
The data from the DMH Nursing Administration of PRNs audit for May-October 2007, based on a mean audited sample size of 3%, indicated:

There was documentation in the MTR of the circumstances requiring the PRN medication	74%
There was documentation in the IDN of the circumstances requiring the PRN medication	75%
The documentation included interventions that were attempted prior to the administration of PRN medication	39%

The data from the DMH Nursing Administration of Stats audit for May-October 2007, based on a mean audited sample size of 27%, indicated:

There was documentation in the MTR of the circumstances requiring the Stat medication	68%
There was documentation in the IDN of the circumstances requiring the Stat medication	63%

		The documentation included interventions that were attempted prior to the administration of Stat medication — 40% From my review of 9 individuals (GM, JH, JM, DR, DD, HE, RG, ML, WS) who received a total of 79 PRNs, I found documentation in the IDNs of the specific circumstances warranting the PRN in 56 instances, and documentation of interventions tried prior to the administration of the PRN medication in 18 instances. In addition, I found adequate documentation of the individual's response to the PRN administered in 22 instances. From my review of 8 individuals who received a total of 24 Stat medications(WS, DRD, MB, TA, ML, MAE, LJ, HD), I found documentation in the IDNs of the specific circumstances warranting the Stat in 20 instances, and documentation of interventions tried prior to the administration of the PRN medication in 5 instances. **Current recommendation**: Continue to monitor this requirement.
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue to improve staff competency regarding the documentation of specific indicators describing an individual's response to PRN and Stat medications. **Findings:** No data was provided by PSH regarding this recommendation. **Recommendation 2, June 2007:** Continue training to clarify and specify criteria regarding what should be documented regarding an individual's response to PRN and Stat

medications to ensure consistent data.

Findings:
No data was provided by PSH regarding this recommendation.

Recommendation 3, June 2007:
Continue to monitor this requirement.

Findings:
The data from the DMH Nursing Administration of PRNs audit for July-October 2007, based on a 3% audited sample, indicated:

There was documentation in the IDN and MTR that the nursing staff made an assessment of the individual's response to the PRN medication	65%
There was documentation in the IDN and MTR of specific indicators describing the individual's response to the PRN medication administered, which may include vital signs, the individual's own words or subjective feelings, observed physical signs, and behaviors post PRN medication	47%
The documentation was aligned with the individual's previous assessment	40%

The data from the DMH Nursing Administration of Stats audit for July-October 2007, based on a 26% audited sample, indicated:

There was documentation in the IDN and MTR that the nursing staff made an assessment of the individual's response to the Stat medication	65%
There was documentation in the IDN and MTR of specific indicators describing the individual's response to the Stat medication administered, which may include vital signs, the individual's own words or subjective feelings, observed	34%

		physical signs, and behaviors post Stat medication | The documentation was aligned with the individual's previous assessment | 34% **Current recommendation**: Continue to monitor this requirement.
F.3.b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Continue to revise monitoring tools to include this requirement. **Findings:** See F.3.a.i. **Recommendation 2, June 2007:** Ensure reliability of the data. **Findings:** See F.3.a.i **Recommendation 3, June 2007:** Continue to revise policies and procedures regarding medication variances to include failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log as reportable medication variances. **Findings:** NP 511, Medication Variance Report was revised to adequately address this recommendation. **Recommendation 4, June 2007:** Develop and implement a system to monitor appropriate follow-up to

		prevent recurrence of such variances. **Findings:** PSH has implemented the Medication Pass Observation Monitoring tool, which includes the requirements for signing the MTR during medication pass. In addition, PSH has also implemented a process of weekly review of all medication variances by the Medical Director, Nurse Administrator, Director of Pharmacy, and the Quality Improvement Committee for recommendations and action steps. **Recommendation 5, June 2007:** Provide training to staff regarding the above. **Findings:** PSH indicated partial compliance with training of staff regarding this recommendation, citing 13.5% compliance. **Other findings:** The data provided by PSH could not be interpreted. There was no population defined (N). Consequently the numbers provided for n could not be adequately interpreted. From my discussion with Nursing, it was agreed that PSH would provide data regarding the number of MTR and Controlled Medication log blanks found during their twice-a-month audits and compare to the medication variances. Compliance with number of blanks and medication variances would be reported. **Compliance:** Partial. **Current recommendations**: 1. Present data as described above. 2. Continue to provide training to staff regarding this requirement. 3. Continue to monitor this requirement.

F.3.c	Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue to revise policies and procedures to reflect this requirement. **Findings:** NP 302, Nursing Applications of the Wellness and Recovery Plan has been adequately revised and was in the approval process at the time of this review. **Recommendation 2, June 2007:** Continue to ensure that all nursing staff and psychiatric technicians are competent with regard to the WRP and the Recovery Model. **Findings:** Supporting documentation from the PSH progress report indicated that 36% of RNs, 32% of Psychiatric Technicians, and 21% of LVNs have completed WRP Level 1 training at the time of this review. The Nurse Administrator reported that staffing issues were a barrier to getting more staff to attend the training. **Recommendation 3, June 2007:** Ensure that interventions are written in observable, behavioral, and/or measurable terms. **Findings:** See "Other findings" below. **Recommendation 4, June 2007:** Develop and implement proactive interventions related to the individual's needs and risks.

		Findings: PSH did not provide data addressing this recommendation. **Recommendation 5, June 2007:** Develop and implement a system for presentation of data not appropriate for tables. **Findings:** The data table provided by PSH could not be interpreted as presented. However, below is a narrative summary of PSH's data regarding this requirement as discussed with Nursing during the review. **Other findings:** The data from the DMH Nursing Interventions Monitoring tool audit, from review of 848 charts audited from May-October 2007, indicated: • 6% compliance with the requirement that all nursing interventions are fully integrated into the WRP; • 1% compliance with the requirement that nursing interventions are written in a manner aligned with the rest of the interventions in the WRP; • 1% compliance with the requirement that interventions are written in observable, behavioral and/or measurable terms; • 11% compliance with the requirement that there are no separate nursing care plans other than the interventions integrated in the WRP; and • 6% compliance with the requirement that there are no nursing diagnoses other than as specified in the WRP in terms of the current DSM criteria. From my review of 30 individuals' WRPs (MB, GP, ML, WS, DA, OC, KK, DM, TB, GD CR, JK, HMD, KMH, TEM, JGR , KS, RR, TT, JS, AB, MJ, RC, AC, KC, EYB, RA, MC, PT, CW), I found that 28 did not address

		issues identified from the admission assessments and/or medical problem list; 29 did not include interventions that were written in observable, behavioral and/or measurable terms; and six did not include nursing diagnoses other than specified in the WRP in terms of current DSM criteria. In addition, I could not find documentation that most interventions listed in the WRPs were actually being implemented for all 30. **Compliance:** Partial. **Current recommendations:** 1. Develop and implement proactive interventions related to the individual's needs and risks. 2. Present data in a manner that is able to be interpreted. 3. Same as C.1.a, Recommendation 3. 4. Continue to monitor this requirement.
F.3.d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Provide training to nursing staff regarding therapeutic interactions to improve staff's ability to interact with individuals. **Findings:** PSH's progress report did not address this recommendation. **Recommendation 2, June 2007:** Develop a system to identify target population without duplication of data. **Findings:** PSH's data did not address this recommendation.

		Recommendation 3, June 2007: Continue to monitor this requirement. **Findings:** PSH's progress report indicted that for this requirement, an assigned Standards Compliance auditor interviews two staff on AM and PM shifts on each unit each month. From 223 nurses interviewed from May-October 2007, data from the DMH Nursing Services Nursing Staff Working With an Individual Shall be Familiar Monitoring Tool indicted that 67% of Nursing staff working with the individuals were able to state their life goals; 67% of Nursing staff were able to state one objective for a selective focus; 67% of Nursing staff were able to state mall service(s) and/or interventions for this objective; and 79% of Nursing staff were able to state therapeutic milieu intervention(s) for this objective. From my discussion with Nursing, it was reported that these overall compliance rates were actually higher than they should be due to past auditors allowing staff to use the individuals' charts to answer the interview questions. Nursing reported that this issue has been addressed and resolved. **Other findings:** In reviewing the process for the WRPCs, nursing staff who are assigned to take care of the individuals are consistently not the same nursing staff attending the WRPCs. In addition, PSH has a significantly low percentage of nursing staff who have received Level I WRP training (See F.3.c). These are substantial barriers to achieving compliance with this requirement. From my discussion with Nursing during the review, there has been no plan to address these issues thus far. **Compliance:** Partial.

		Current recommendations: 1. Evaluate staffing patterns to ensure consistent and appropriate nursing staff attendance at the WRPCs. 2. See F.3.c, Current Recommendation #3. 3. Identify target population for data (N). 4. Continue to monitor this requirement.
F.3.e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Develop and implement a system for monitoring and tracking all the elements of this requirement. **Findings:** From my past and current reviews at PSH, I have discussed the elements of this requirement with nursing, describing a chart audit addressing individuals who have had a change in status (such as an emergency room visit, hospitalization, or transfer to the medical unit) to ensure that nursing staff timely monitor, document and report the status of individuals' symptoms, target variables, health and mental health in a manner that enables interdisciplinary teams to assess each individual's status and response to interventions and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Thus far, PSH has not developed a monitoring and tracking system for all the elements of this requirement. **Recommendation 2, June 2007:** Develop and implement policies and procedures addressing criteria for shift change reports. **Findings:** Since the process for shift report has not been fully developed, this

		recommendation has not yet been addressed. **Other findings:** PSH's data from the WRPC Attendance and Nursing Participation Monitoring audit for May-October 2007, from a 17% mean audited sample of WRPCs each month, indicated: • 36% compliance with the requirement that assessments are reviewed at every scheduled WRPC (RN communicates clinically relevant findings); • 31% compliance with the requirement that the RN discussed implications for nursing interventions based on the current nursing assessment; • 34% compliance with the requirement that the RN reports the status of symptoms, progress towards meeting target variables, and mental health status of the individuals to enable the WRPT to assess his/hers status and to assist in developing or modifying the WRP; and • 25% compliance with the requirement that the Psych Tech/LVN reports to the WRPT daily observations of symptoms, target variables, and response to interventions. Clearly issues regarding Wellness and Recovery training and ensuring consistent and appropriate staffing at the WRPs will need to be addressed to increase compliance rates. From my review of the nursing documentation for 11 individuals (JCP, JCS, MAS, SLT, FGP, TMA, PRM, WPW, JT, GH, HR) who were sent to the community emergency room/hospital for acute illness/injury issues, I found the following problematic issues: • FGP: Sent to Emergency Room (ER) on 6/16/07, 6/18/07 6/22/07, 6/29/07 for priapism. Nursing documentation for

		each incident included vital signs, pain assessment, and timely notification of physician prior to ER visit. However, there were no notes describing FGP's status upon return from the ER. In addition, the weekly note for 6/14/07-6/23/07 did not include any of the ER visits for priapism. • HR: Sent to ER 10/23/07 for seizures. The RN progress note and RN Nursing Process for Activating Event note was basically thorough with the exception of documentation of HR's respirations during her seizure activity. However, the RN notes indicated that she was not at the scene at the time when the seizure activity began. A note from a PT only indicated the time she had a seizure and the time she was transported to the hospital. No description of the activity was provided by the PT. • JCP: Sent to ER on 11/2/07 for coffee-ground emesis. RN note on Activating Event form illegible. No status notes in record from nursing from 11/3-11/5 while hospitalized. • JT: Sent to ER on 9/30/07 for left acute abdominal pain. I found no nursing note indicating that JT was sent to the hospital and was admitted for acute abdominal pain. The only note I found was for 10/2/07 indicating that she had been hospitalized. • PRM: Sent to ER 6/22/07 for seizures. The progress note from the RN lacked a description of PRM's seizures. In addition, I found no indication that neuro checks were done since her seizures happened after an attack by a peer. Also, there was no description of PRM upon return from the ER. The last progress note for 6/23/07 indicated that she would be monitored. However, the next progress note was dated 7/23/07.

		• TMA: Sent to ER 7/5/07 for pneumonia. Copies provided by the facility did not contain progress notes for this incident. Unable to review. • WPW: Sent to ER on 6/15/07 for evaluation of edema to lower extremities. Nursing notes for 6/15/07 basically illegible. Swelling to lower extremities documented on 6/14/07. However, no indication of degree of pitting edema for future comparison. No progress notes from 6/16/07-6/18/07 updating his status. • MAS: Sent to ER on 5/11/07 for bilateral pneumonia. Many nursing progress notes difficult to read. Notes indicated a cough on 3/16/07 but no follow-up was found. A number of nursing notes out of order and difficult to follow the sequence of events. No indication of updates while hospitalized from 5/12/07-5/19/07. No indication that lung sounds were monitored upon return from hospital. • JCS: 5/3/07 sent to ER for abdominal pain and vomiting. RN note indicated that JCS vomited three times. However, I found no documentation of each episode with an associated assessment. In addition, there was no documentation that bowel sounds were assessed for an individual complaining of abdominal pain. The nursing note for 5/5/07 indicated that JCS died at the hospital but no preliminary cause of death was included in the documentation from communication with the hospital. • SLT: 7/30/07 sent to ER for osteomyelitis. No description documented of ulcers to fingers and left foot prior to leaving for ER. Nursing notes out of order. No nursing note the day he

		returned from hospital. • GH: Sent to ER on 9/17/07 for blisters/lesions to lower extremities. No nursing note documenting when he actually left the facility to go to the ER. A number of nursing notes stating vital signs within normal limits (WNL) but no actual values documented for comparison. No specific description of lesions to determine whether they are better or worse. Nursing notes out of order. Regarding shift change, PSH's data from the DMH Nursing Shift Change Monitoring audit from May-October 2007, based on an audited sample size of 57% of shift reports (including both AM and PM reports), indicated: • 2% compliance with the requirement that Nursing shift change included a review of changes in status of individuals (excluding data for September and October for this item); • 8% compliance with the requirement that the individuals response to active treatment was addressed; • 16% compliance with the requirement that when new clinical data was presented, the staff discussed information/change from baseline data; • 2% compliance with the requirement that when a significant clinical change was noted, that staff reviewed and compared baseline data for any necessary modifications to interventions in the WRP; • 0% compliance with the requirement that when new change/significant clinical data was presented, the individuals strengths, stages of change were discussed in planning for the interventions and the WRP; and • 3% compliance with the requirement that if any individual was scheduled for diagnostic procedures/consultation, the consent

		was prepared, transportation and escort addressed. PSH reported that criteria for change of shift continue to evolve and that unit EB-09 is piloting a system for shift change. From my observation of a shift report on this unit during the review and discussions with the staff from this unit, I found that much more pertinent information was shared during this shift report than others I had observed in the past. PSH needs to continue to develop and implement a structure for shift report. **Compliance:** Partial. **Current recommendations**: 1. Evaluate staffing patterns to ensure consistent and appropriate staff attendance at the WRPCs. 2. See F.3.c, Current Recommendation #3. 3. Review documentation guidelines for acute illness and injuries to ensure that they meet generally accepted professional standards of nursing practice. 4. Develop and implement a structure for shift report. 5. Develop/revise policies and procedures to reflect changes in process for shift report. 6. Continue to monitor this requirement.
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	**Compliance:** Partial.
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Implement a monitoring and tracking system to ensure nursing staff

		are knowledgeable regarding each individual's prescribed medications. **Findings:** Thus far, PSH has implemented a system in which an auditor monitors the morning medication pass for five individuals. After this observation, the auditor interviews the staff to determine staff's knowledge regarding the prescribed medications and these findings are then inputted into the PLATO System for tracking. **Recommendation 2, June 2007:** Develop and implement a system to ensure that every nurse that administers medication is observed on a quarterly basis. **Findings:** Standards Compliance at PSH provides the monitoring data of staff that have been observed passing medications, which has become the actual tracking log. Thus far, the facility has not observed every nurse that administers medication on a quarterly basis. **Recommendation 3, June 2007:** Develop a system to identify target population without duplication of data. **Findings:** Same as above. **Other findings:** The data from the Statewide Medication Administration Monitoring audit for May-October 2007, based on 222 staff medication administration observations, indicated that 76% were able to verbalize the generic and trade names of the medication administered; 75% were able to describe the therapeutic effects, usual dose, and routes of medication administered; and 48% were able to differentiate expected

		side effects from adverse effects. **Current recommendations**: 1. Provide data indicating that every nurse that passes medications have been observed every quarter. 2. Continue to monitor this requirement.
F.3.f.ii	education is provided to individuals during medication administration;	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Develop and implement a monitoring and tracking system to ensure nursing staff are knowledgeable regarding each individual's prescribed medications. **Findings:** PSH has revised the monitoring tools that specifically define criteria for compliance. In addition, the PLATO system will define the staff that was monitored. **Recommendation 2, June 2007:** Ensure staff competency regarding the implementation of this requirement. **Findings:** Same as above. **Other findings:** The data from the Statewide Medication Administration Monitoring audit for May-October 2007, based on 222 staff medication administration observations, indicated that the individual was educated regarding medications in 23% of observations.

		Current recommendations: Continue to monitor this requirement.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as in F.3.f.i. **Findings:** Same as in F.3.f.i **Other findings:** The data from the Statewide Medication Administration Monitoring audit from May-October 2007, based on 222 staff medication administration observations, indicated: • 68% compliance with the requirement that principles of asepsis were applied to medication administration; • 95% compliance with the requirement that medications were prepared/organized no more than one hour before administration; • 95% compliance with the requirement that individuals were identified by name and photograph to ensure correct identification; • 99% compliance with the requirement that staff measured, interpreted and recorded blood pressure and pulse before administering cardiac and antihypertensive medications or withholds as indicated; • 99% compliance with the requirement that staff opened/poured medication in front of individual; • 62% compliance with the requirement that medication was checked with the MTR three times; • 94% compliance with the requirement that staff ensured that

		individual swallowed all medications; • 38% compliance with the requirement that staff applied proper technique with use of safety syringes; and • 96% compliance with the requirement that staff ensured individuals' privacy and confidentiality. **Current recommendations**: Continue to monitor this requirement.
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as in F.3.f.i. **Findings:** Same as in F.3.f.i **Other findings:** The data from the Statewide Medication Administration Monitoring audit for May-October 2007, based on 222 staff medication administration observations, indicated 95% compliance with the requirement that staff documented medication that is given on the MTR immediately after administering. **Current recommendations**: Continue to monitor this requirement.
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue to monitor this requirement.

		Findings: PSH did not have any individuals that were bed-bound from May-October 2007 or at the time of this review. However, NP 330 adequately addresses bed-bound individuals and a tool to monitor this requirement is being developed by PSH in the event this situation occurs. **Compliance:** Partial. **Current recommendations**: 1. Develop a monitoring tool to address this requirement. 2. Continue to monitor this requirement.
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	**Compliance:** Partial.
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Develop and implement a monitoring instrument and tracking system to address this requirement. **Findings:** PSH has required that all new licensed Nursing staff receive competency-based training in the Science of Forensic Mental Health Nursing class in New Employee Orientation. **Recommendation 2, June 2007:** Ensure that the training provided regarding this requirement is competency-based.

		Findings: Same as above. **Other findings:** The data from the Staff Development Center New Employee Training Records audit indicated that the six new RNs and 26 LVNs and Psychiatric Technicians hired during May-October 2007 were competent in mental health principles. However, no data was provided regarding existing staff's compliance with this requirement. **Current recommendations:** 1. Provide data for existing nursing staff for this requirement. 2. Continue to monitor this requirement.
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure that there are training classes to specifically address therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises. **Findings:** Training for Therapeutic Milieu is being conducted by the Staff Development Center. Thus far, only two units have received this training. The training records from PSH indicated that 77% of staff have received PBS training. **Recommendation 2, June 2007:** Revise monitoring instrument to align with the EP. **Findings:** The data for this recommendation did not address this requirement

		regarding competency-based training. **Recommendation 3, June 2007:** Present data for this requirement in a meaningful way. **Findings:** Same as above. **Current recommendations**: 1. Continue training to address this requirement. 2. Provide data regarding this requirement.
F.3.h.iii	positive behavior support principles.	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Develop and implement a monitoring instrument and tracking system to address this requirement. **Findings:** Tracking conducted by the Staff Development Center adequately addresses this recommendation. **Recommendation 2, June 2007:** Continue to monitor and track attendance at PBS training. **Findings:** The data from PSH indicated that all new RNs, LVNs, and Psychiatric Technicians hired from May-October 2007 have received training in PBS. (See F.3.h.ii.) **Current recommendations**: Continue to monitor this requirement.

F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Submit compliance data related to this requirement. **Findings:** Appropriate compliance data addressing this requirement is presented below. **Findings:** The data from PSH indicated that all new RNs, LVNs, and Psychiatric Technicians hired from May-October 2007 were competent in completion of the MTR and the controlled medication log. The data for existing staff indicated 67% compliance with the requirement of annual training in Principles of Medication. **Compliance:** Partial. **Current recommendations:** Continue to monitor this requirement.

4. Rehabilitation Therapy Services		
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Greg Siples, Chief of Rehabilitation Services 2. Brian Starck-Riley, Clinical Dietitian 3. Denise Byerly, RN, Dysphagia Team Coordinator 4. Michael Gomes, Recreation Therapist 5. G. Michelle Reid-Proctor, MD, Physical Medicine and Rehabilitation 6. Janet Richards, Occupational Therapist 7. Mark Camero, Supervising Rehabilitation Therapist 8. Jacqueline Doss-Haynes, Supervising Rehabilitation Therapist 9. Tai Kim, Director of Nutrition Services 10. Kurt Reich, Program Director 11. Roger Rhodes, Occupational Therapist 12. Victor G. Ruiz, Speech Pathologist 13. Jerry Marquez, Physical Therapist Assistant 14. Louis F. Lacouette, Physical Therapist 15. Billy Mange, Senior Vocational Rehabilitation Counselor 16. Jay Gehrke, Industrial Therapist 17. Lorraine A. Nicklin, Teacher 18. Joseph Malancharuvil, Clinical Administrator 19. Mel Byde, PhD, Acting Mall Director 20. Julie Garvey, Unit Supervisor 21. Paula Quinones, Special Education Teacher 22. Individuals BP, JCH and JM Reviewed: 1. PSH Rehabilitation Therapy Manual 2. Rehabilitation Monitoring F4 tool outline 3. PSH Rehabilitation Therapy (Physical/Occupational) Audit 4. AD #10.21 Activity Program for Individuals Served (implemented 9/19/07)

		5. AD #10.18 Physical/Occupational Therapy Services (implemented 7/15/07) 6. AD #10.27 Speech Pathology and Audiology (implemented 6/18/07) 7. AD #10.44 Aspiration and Dysphagia Management (implemented 7/15/07) 8. AD #10.45 Use of Wheelchairs 9. Monthly Wheelchair Maintenance Checklist 10. Wheelchair Repair Request 11. Staff training attendance sheets for adaptive equipment training and corresponding competency checklists for TENS unit training 12. AD #10.01 PSH Clinics, Consultants and Referral Services 13. Horticulture program information 14. V.I.C.T.O.R.Y Proposal Manual 15. Dysphagia and Aspiration Identification and Support Processes flow sheet 16. Dysphagia and Aspiration Management Monitoring Tool 17. Nursing Policy and Procedure 319: Dysphagia and Aspiration Management (implemented 4/07) 18. WRP documents for the following individuals participating in observed Mall groups: 19. Curricula, lesson plans, and rosters for the following observed RT-led Mall groups: 20. List of "Mobility Impaired" individuals 21. List of individuals with Dining Plans developed/implemented from May-October 2007 22. Assessments and corresponding WRPs of the following individuals who had a Dining Plan based on Comprehensive Assessment for Dysphagia and Aspiration Management from May-October 2007: JJD, PGL, DWL, JCB, JLT, RB, RH, AAA, JDH 23. List of individuals who had Occupational Therapy direct treatment from May-October 2007 24. Assessments and corresponding WRPs of the following individuals who had Occupational Therapy assessment/consultation from May-

		October 2007: NGF, RCG, RRL, MJC, JB, CC, MAT 25. Records for the following individuals receiving OT direct treatment from May-October 2007: JR, LRP, JH 26. List of individuals who received direct Physical Therapy services from May-October 2007 27. Records for the following individuals who had Physical Therapy assessment/consultation from May-October 2007 to compare assessments and corresponding WRP's: JM, VA, BMP, MN, FC, VQ, KS, JD, JM, AW 28. Records for the following individuals who received direct Physical Therapy services between May-October 2007: DC, TA 29. List of individuals who direct Speech Therapy services from May-October 2007 30. Assessments and corresponding WRPs for the following individuals who had Speech Therapy assessment/consultation from May-October 2007: AB, CC, CMF, DAR, HLS, BMP, CAW, DLW 31. Records for the following individuals who received direct Speech Therapy services from May-October 2007: RWT, KH, MEB, AA <u>Observed</u>: 1. Exercise: Aerobics group 2. Mood Management Through Poetry and Journaling group 3. Songwriting for Self-Discovery group 4. Easy Street program 5. Mindfulness- Weight Training group 6. New Horizons Music group 7. Crochet group 8. The following individuals in direct Physical Therapy treatment: JM, BP 9. The following individual in direct Occupational Therapy treatment: JCH 10. The following individuals in EB 11 with Dining Plans during lunch meal: JD, RB, HS, RC

F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	**Compliance:** Partial.
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	**Current findings on previous recommendation:** **Recommendations 1-2, June 2007:** • Continue to revise policies and procedures to include principles and language of the Wellness and Recovery Model, psychiatric rehabilitation, and recovery principles. • Continue the process of integrating OT, PT, and Speech Therapy into the Rehabilitation Department. **Findings:** AD #10.21, Activity Program for Individuals Served has been revised to include Wellness and Recovery language. However, the procedure is brief and does not include the number of hours of service provision required as indicated by the PSR Manual, or provide specific information regarding lesson plans, curricula, and evidence-based practice/practice-based evidence. The procedure also indicates that RT annual assessments should be done, which is not required by the EP. AD #10.45, Use of Wheelchairs does not reflect language and philosophy of the Wellness and Recovery model. Rehabilitation Therapists are required to attend all WRPCs. Currently, Physical, Occupational, and Speech therapists do not attend WRPCs due to low staffing ratios. The Physical and Speech Therapist and one of the two Occupational Therapists have not received training regarding the Wellness and Recovery model or the Enhancement Plan. Upon record review and interview, it was noted that PT, OT and ST are

		inconsistently reporting information related to objectives and intervention using the WRP attachment, which is often not incorporated into the WRP. Physical/Occupational Therapy procedure states that therapists are to document progress into the ID note, but this information is not being carried over into the WRP. Speech Pathology and Audiology procedure does not specify a means by which the Speech Therapist documents progress, or how progress towards objectives is integrated into the WRP. The Speech Pathology & Audiology procedure requires that Speech Therapy direct treatment is initiated within seven days of treatment order. The Physical/Occupational Therapy procedure does not indicate a timeframe in which treatment should be initiated following referral. Currently, there is not a procedure in place to determine when an individual requires an Individual Rehabilitation Service Plan (formerly a Dining Plan), nor is there a consistent format by which this plan is developed, implemented with competency-based training as needed and monitored as needed. There is no procedure in place to determine when competency-based training or monitoring is needed to ensure adaptive equipment implementation. **Recommendation 3 and 4, June 2007:** • Revise monitoring instrument to ensure accurate data and include Speech Therapy. • Continue to monitor this requirement. **Findings:** An F.4 monitoring tool outline has been implemented (9/07) which lists the Enhancement Plan cells. However, no instructions have been developed, and therefore inter-rater reliability has not been established. The current tool and data gathered and presented for September and October 2007 is vague and does not appear to be

		reliable and valid. It is unclear how various samples were defined and selected and how compliance/scoring was determined. The F.4 monitoring tool should include audit of all Rehabilitation Services disciplines, including Physical Rehabilitation, Psychosocial Rehabilitation and Vocational Rehabilitation direct and indirect services. Direct services include Mall groups and 1:1 therapy interventions. Indirect services include training and monitoring of Individual Rehabilitation Service Plans, individual exercise plans, and adaptive equipment as needed. The monitoring tool should assess quality of services, timeliness of services, and WRP integration. **Current recommendations**: 1. Develop and implement a procedure that specifies criteria for the need for and implementation of a 24-hour support plan (Individual Rehabilitation Support Plan) related to physical and nutritional rehabilitation supports. 2. Develop and implement a system by which assessment/consultation findings, recommended supports/objectives and progress toward these objectives can be reported to the WRPT by all Rehabilitation Therapy Services disciplines. 3. Provide competency-based training to Rehabilitation Therapy staff regarding Recommendation #2. 4. Ensure that all Rehabilitation Therapy staff is provided competency-based training on all procedures related to the Enhancement Plan, Wellness and Recovery model, and Psychosocial Rehabilitation Mall, including Mall Facilitator Monthly Progress notes and writing of lesson plans/curricula. 5. Develop and implement an audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment (1:1 and group) and indirect supports (e.g., Individual Rehabilitation Support, adaptive equipment). Implementation findings should include recommendations regarding foci, objectives and interventions made by Rehabilitation Therapy

		Services, quality of these objectives regarding Wellness and Recovery criteria, documentation of progress towards objectives, modification of objectives/ interventions as needed, and WRP inclusion. 6. Establish inter-rater reliability among staff performing audit prior to implementation.
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Develop and implement a system to provide regular oversight by rehabilitation therapists to nursing staff implementing individualized programs. • Develop and implement a monitoring system to ensure that oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff is occurring. **Findings:** According to facility report, Physical Therapy Treatment direct treatment programs are developed by the Physical Therapist and implemented by the Physical Therapist or Physical Therapy Assistant. Exercise programs are also developed and implemented by the Occupational Therapist. Individuals who have met PT/OT goals for independence with exercise programs are discharged from 1:1 therapy and exercise programs are implemented by the individual on his/her unit. Staff should be trained when an individual is not independent in the home program. However, there is no database or monitoring tool in place to monitor when this training is required on an individualized basis, how often it should be monitored, and who is responsible for monitoring.

		Current recommendation: Develop and implement a plan to ensure that in vivo monitoring of Physical Therapy programs implemented by nursing staff or individuals themselves occurs as needed.
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Develop and implement a system to provide and document competency-based training on this requirement. • Develop and implement a monitoring system to ensure that competency-based training is provided for this requirement. **Findings:** According to facility report, 18 staff were trained in use of a walker on 7/17/07, 7/27/07, 8/01/07; nine staff were trained on walker/cuff use on 8/23/07; three staff were trained on sock aid use on 8/23/07; 15 staff were trained in the use of a TENs unit on 7/20/07; and 16 staff were trained in adaptive equipment use (non-specific) on 6/19/07, 6/26/07. This is verified by review of attendance sheets. However, there was no data provided regarding a total of how many individuals/ staff required training with adaptive equipment, transferring and positioning versus how many received training, and therefore no finding regarding compliance can be made based on the data presented. There is no database or monitoring tool in place to monitor when this training is required on an individualized basis, how often it should be monitored, and who is responsible for monitoring. **Compliance:** Partial.

		Current recommendation: Develop and implement a plan to ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, occurs as needed.
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendations:** **Recommendations 1-3, June 2007:** • Develop and implement a system to adequately monitor this requirement. • Review policies and procedures for referrals and revise as needed. • Revise the monitoring tool for this requirement to ensure adequate and appropriate data. **Findings:** No monitoring system for F.4 has been developed. See F.4.a for findings regarding this recommendation. **Other findings:** Upon observation of six Mall groups lead by RTs, it was noted that none had comprehensive lesson plans/curricula; all individuals were engaged in three out of six groups, and partial engagement was noted in three out of six groups. Upon review of a sample of WRPs of individuals who participated in Mall groups facilitated by psychosocial Rehabilitation Therapists, and individuals who have received Integrated Rehabilitation Therapy Assessments, a weighted average rate of attendance by Rehabilitation Therapist at WRPCs was noted to be 68%.. Record review of IRTA assessments and pilot assessments showed that 43% of WRP documents contained evidence of RT recommendation

		inclusion. Upon review of WRP documents for the random sample of individuals participating in observed Mall groups, it was noted that 5% of objectives were functional, individualized and measurable; 16% had measurable and specific interventions pertaining to the observed group, and 0% of individuals were in a group recommended by Rehabilitation Services assessment. Upon review of Physical, Occupational, and Speech Therapy treatment plans, it is noted that none of the reviewed plans were written in accordance with WRP requirements of listing focus, objective, and intervention, but rather reflect the medical model language of long-term and short-term objectives. A review of a sample of records of individuals receiving Physical Therapy assessment (in which recommendations were made) revealed that two out of eight WRP documents included Physical Therapy assessment findings and recommendations. A review of a sample of Speech Therapy assessments (in which recommendations were made) and corresponding WRPs revealed that one out of four WRP documents included Speech Therapy assessment findings and recommendations. A review of a sample of Occupational Therapy assessments (in which recommendations were made) and corresponding WRPs revealed that two out of eight WRP documents included Occupational Therapy assessment findings and recommendations. According to facility report, 26 individuals received direct Physical Therapy treatment in the month of October 2007. Upon review of two records of individuals receiving direct Physical Therapy treatment, it was noted that both contained IDN documentation of progress, but this progress was not incorporated into the WRP. Neither of the records listed functional and measurable foci, objectives, or

		interventions pertaining to direct PT treatment in the WRP. According to facility report, nine individuals received direct Speech Therapy treatment from June-October 2007. Upon review of records for four individuals receiving direct Speech Therapy treatment, it was noted that three contained IDN documentation of progress, but this progress was not incorporated into the WRP. None of the four records listed functional and measurable foci, objectives, or interventions pertaining to direct ST treatment in the WRP. According to facility report, nine individuals received direct Occupational Therapy treatment in the month of October 2007. Upon review of three records of individuals receiving direct Occupational Therapy treatment, it was noted that all three contained IDN documentation of progress, but this progress was not incorporated into the WRP. None of the three records listed functional and measurable foci, objectives, or interventions pertaining to direct OT treatment in the WRP. All three individuals observed in direct PT/OT treatment were engaged in activities related to treatment objectives. Upon interview with these individuals, it was noted that individuals were aware of treatment objectives and verbalized positive gains from direct treatment. Vocational Rehabilitation (V.I.C.T.O.R.Y) proposal has been developed but has not been implemented. This proposal is an excellent start, and should be provided in alignment with the PSR Mall and Wellness and Recovery principles. Four individuals with Dining Plans developed were observed during mealtime. Two out of four had Dining Plans implemented, and one out of four did not appear to have a Dining Plan that was appropriate and adequate to maximize function and safety.

		Facility data regarding facilitator hours was difficult to interpret and appear to be provided per Mall, therefore, no findings regarding compliance based on this data can be made at this time. This data should be reported in order to determine the average number of hours provided per week by therapist according to facility requirements, as well as the number of hours scheduled versus provided. For data analysis and performance improvement, averages by individual, by discipline, and by RT department should be provided. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a plan to track Rehabilitation Therapy staff attendance at WRPCs. 2. Ensure WRP inclusion of recommendations regarding foci, objectives and interventions made by Rehabilitation Therapy Services, quality of these objectives regarding Wellness and Recovery criteria, and progress towards objectives. 3. Ensure that all Mall groups facilitated by Rehabilitation Therapists have requisite lesson plans and curricula per PSR Mall standards. 4. Track the number of hours provided per week by therapist according to facility requirements, as well as the number of hours scheduled versus provided, and calculate averages per therapist, discipline and department for performance improvement purposes. 5. Develop and implement Vocational Rehabilitation (V.I.C.T.O.R.Y) program and ensure that it reflects Wellness and Recovery language and philosophy.
F.4.d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive	**Current findings on previous recommendation:**

	equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	**Recommendation, June 2007:** Develop and implement a system to monitor the elements of this requirement. **Findings:** According to a review of the Mobility Impaired Individuals database, 28 individuals currently require use of a wheelchair and/or walker. Other types of adaptive equipment are not currently tracked and no data was available. There is currently no monitoring tool in place to audit for implementation of services related to adaptive equipment. **Compliance:** Partial. **Current recommendations:** 1. Develop and implement a plan to ensure that in vivo monitoring of adaptive equipment occurs as needed on an individualized basis by a professional with clinical expertise to determine compliance with both implementation and continued appropriateness of supports. 2. Develop and implement an adaptive equipment database to track when a piece of equipment is ordered, the date of implementation, level of assistance to the individual with device, whether training/ monitoring is necessary, and when training/monitoring is provided, if appropriate.

5. Nutrition Services		
	Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Tai Kim, Director of Nutrition Services 2. Kitchie Miana, Assistant Director of Nutrition Services 3. Dolores Otto Moreno, Assistant Director of Nutrition Service 4. Grace Ferris, Assistant Director of Nutrition Services Reviewed: 1. Meal Accuracy Report data for September and October 2007 2. DMH Nutrition High Risk Referral 3. DMH Nutrition Care Process 4. DMH Statewide Dietetics Department Policy, Clinical Nutrition-Weight Management Protocol (implemented 10/10/07) 5. 12 Week Curricula for Weight Management, General Nutrition, Chronic Diseases (Hepatic, HIV, Cancer, and Renal), Cardiovascular Disease, and Diabetes Management 6. Records for the following individuals receiving type a. assessments from May-October 2007: VQ, BMP, RH, DL 7. Records for the following individuals receiving type d. assessments from May-October 2007: JMP, PS, PJS, HS, LHK 8. Records for the following individuals receiving type e. assessments from May-October 2007: JGP, ACP, JH, RCM, TGA, EBW, CB 9. Records for the following individuals receiving type f. assessments from May-October 2007: JAG, IAD, CGW, JM, MAS 10. Records for the following individuals receiving type g. assessments from May-October 2007: JML, DR, SJW, YEH, HCC, RK, NT, CB 11. Records for the following individuals receiving type i. assessments from May-October 2007: AHG, JDK, ARB, JM, DP, MJT, JFP, HLE, JP, GRH, DAP 12. Records for the following individuals receiving type j.i. assessments from May-October 2007: IC, RLB, LLF, RLC, TRF, WL, RB, AAA,

		RO, EC 13. Records for the following individuals receiving type j.ii. assessments from May-October 2007: BM, JAM, PWW, BM2, BEK, WMP, MH, TCH, GLT, DEA, CDA
F.5.a	Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue to revise policies, procedures, protocols, and ADs to address this requirement. **Findings:** The DMH Statewide Policy: Nutrition Assessment, Nutrition High Risk Referral, Dietetics Department Policy, Clinical Nutrition- Weight Management Protocol, and Nutrition Discharge Summary have been revised, and upon review appear to meet accepted standards of practice. Twelve-week curricula for Nutrition Mall groups have been developed for: Weight Management, General Nutrition, Chronic Diseases (Hepatic, HIV, Cancer, and Renal), Cardiovascular Disease and Diabetes Management. Upon review of these curricula, it is noted that they appear to meet requirements of the PSR Mall/Enhancement Plan. **Recommendations 2-4, June 2007:** • Implement a system addressing WRP strategies for weight-related triggers. • Ensure staff competency regarding weight-related triggers. • Implement a monitoring instrument and tracking system addressing the elements of this requirement. **Findings:** According to facility report, Monthly Weight and Vital Sign Sheet is

		completed by LOC staff by the seventh day of the month and is sent to the Physician, Dietitian and Standards Compliance. Standards Compliance collects the data monthly and findings are sent to each unit and presented to the QIT committee monthly. RDs receive Monthly Weight and Vital Sign Sheets each month, and data is entered into Computrition Database. An assessment is completed when there is a significant change in condition and incorporated into WRP when indicated. See F.4.b for findings regarding WRP integration. **Other findings:** The Meal Accuracy Report was implemented 9/07, though accuracy of modified diets has been audited routinely as part of the performance improvement process. The meal accuracy report will formalize tracking to ensure accurate implementation of the diet order component of nutrition recommendations. The target sample is ≥20% of all diets (regular and modified). According to facility report, trays (regular and modified diets) audited in September (total of 886) were 96% accurate and trays audited in October (total of 720) were 98% accurate. Nutrition Education/Training is a direct service provided by dietitians to individuals and is based on objective assessment findings. According to record review of assessments completed (total of 48), an average (weighted mean) of 96% of Nutrition Care Assessments had evidence of Nutrition Training/Education. According to record review of assessments completed (total of 49), an average (weighted mean) of 94% of Nutrition Care Assessments had evidence of individual response to MNT (Medical Nutrition Training). Facility database for all assessment types per month for May-October 2007 was reviewed and weighted mean revealed that 88% of assessments audited from May-October had evidence of Nutrition

		Education/Training and 97% had evidence of individual response to MNT. Facilitator hours by dietitians are not currently tracked and were not provided to this reviewer, but are requested for next review. **Compliance:** Partial. **Current recommendations**: 1. Track Mall Facilitator hours by Dietitians. 2. Continue current practice.
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Develop and implement a monitoring system to ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues. • Implement the statewide training tool for the regarding this requirement. **Findings:** RN training "Nutrition Assessment and Incorporation into the Wellness and Recovery Plan" lesson plan, curriculum and post-test have been developed and implemented. According to facility report, 71 RNs have been trained out of 333 filled RN (Safety) positions as of October 2007. **Other findings:** Upon record review of all Nutrition Care assessments completed (total

		of 43), it was noted that 63% of corresponding WRPs contained Nutrition Care objectives/diagnosis/recommendations. According to facility report of audit data (n of 162) for September and October 2007, 68% of corresponding WRPs contained Nutrition Care objectives/diagnosis/recommendations. **Compliance:** Partial. **Current recommendation**: Continue current practice.
F.5.c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.	**Current findings on previous recommendations:** **Recommendations 1 and 4, June 2007:** • Provide ongoing training regarding this requirement. • Provide competency-based training to staff regarding risk of aspiration/dysphagia. **Findings:** See F.5.d for findings regarding this recommendation. **Recommendation 2, June 2007:** Continue to revise policies and procedures in accordance with generally accepted standards of practice regarding risk of aspiration/ dysphagia. **Findings:** The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management was revised and implemented in October 2007. This procedure addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice.

		Recommendations 3 and 5, June 2007: • Continue to develop and implement 24-hour, individualized dysphagia care plans. • Provide competency-based training on individualized, 24-hour dysphagia care plans to staff working with individuals at risk of aspiration/dysphagia. **Findings:** Assessment of swallowing, dysphagia risk, aspiration risk, and mealtime interventions/24-hour supports does not fall within the scope of practice for registered dietitians. The role of the dietitian as a team member in serving individuals at risk for dysphagia and aspiration is well established within current procedures related to dysphagia. **Recommendation 6, June 2007:** Continue to revise and implement a monitoring system for this requirement. **Findings:** Procedures have been approved by statewide committee and upon review appear to meet generally accepted standards of practice. Therefore, it does not appear necessary to develop a monitoring tool to ensure compliance with this requirement. **Recommendation 7, June 2007:** Develop appropriate clinical monitoring and review for acuity levels of dysphagia. **Findings:** This previous recommendation is applicable to D.5.h. Refer to D.5 for corresponding findings.

		Compliance: Substantial, based on the scope of practice of dieticians. **Current recommendation**: Continue current practice.
F.5.d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Ensure competency-based training of staff regarding the implementation of this requirement. • Implement a system to monitor this requirement. **Findings:** At the time of the last review, it was noted that all dietitians received Dysphagia Training provided by the consultants Bailey and Associates. Since the last review, two new dietitians have been hired and both have attended Dysphagia Awareness Training as part of New Employee Orientation. This is verified by review of sign-in sheets, though no post-test data was available. Dietitian training regarding procedures related to dysphagia and aspiration is monitored within the department database. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.e	Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Continue to revise policies and procedures to reflect the elements

	these treatment options are utilized, to determine the feasibility of returning them to oral intake status.	of this requirement. • Implement a system to monitor this requirement. **Findings:** The role of the dietitian related to individuals who are receiving enteral nutrition is clearly defined in the Statewide Dietetics Tube Feeding Policy. Assessment of P.O. status does not fall within the scope of practice for registered dietitians, but should be addressed by the WRPT with determination based on findings from speech therapy, physician, and nurse assessments as well as objective diagnostic test findings. **Compliance:** Substantial. **Current recommendations**: 1. Continue current practice. 2. Collaborate with relevant disciplines (e.g., SLP, Nurses, Physicians) to develop and implement a plan/procedure to ensure ongoing assessment of the individuals receiving enteral nutrition, to determine the feasibility of returning them to oral intake status or justification of continued NPO status.

6. Pharmacy Services		
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	**Methodology:** Interviewed: 1. Phung Chau, BS, Pharmacy Director 2. Richard Plon, PharmD, Assistant Director 3. Laura Yao, Business Manager Reviewed: 1. Clinical Pharmacy Review forms regarding eight individuals (AB, BB, DDM, GH, BF, EO, NO, and KLK) 2. Pharmacy Policy and Procedure Administration of Medication to Patients, revised September 2007 3. Pharmacy Services Audit Form 4. Pharmacy Services Audit summary data (September and October, 2007)
F.6.a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Revise pharmacy policies and procedures to address this requirement. **Findings:** PSH has implemented this recommendation. The revised policy specifies procedures to implement the new Clinical Pharmacy Review form to formalize the process of review of physician orders by pharmacists. **Recommendations 2-3, June 2007:** • Develop and implement an electronic system to ensure consistent documentation. • Provide IT assistance to pharmacy regarding electronic database and data collection systems.

Findings:
PSH has yet to implement these recommendations.

Recommendation 4, June 2007:
Develop and implement a monitoring tool to ensure the elements of this requirement are adequately addressed.

Findings:
PSH developed the Pharmacy Services Auditing form to monitor this requirement (September 2007). The facility has monitoring data (September and October 2007) based on a review of a 100% sample of new medication orders, including changes to existing orders. The following table summarizes the data regarding number of recommendations made by the pharmacist (#) in each category:

	Sept	Oct	Mean
N	2832	3453	
n	2832	3453	
%S	100	100	
Drug-to-drug interactions	2	0	1
Side-effects	0	0	0
Need for lab work and testing	0	0	0
Others	7	9	8

PSH recognizes the number of recommendations made by the pharmacist is very limited given the total number of orders reviewed. PSH reported that staffing shortage is the main barrier to compliance.

		Compliance: Partial. **Current recommendations**: 1. Ensure that pharmacists provide recommendations, when appropriate, and intensify recruitment efforts to improve compliance. 2. Continue to monitor this requirement. 3. Develop and implement an electronic system to ensure consistent documentation. 4. Provide IT assistance to pharmacy regarding electronic database and data collection systems.
F.6.b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Develop and implement policies and procedures in collaboration with pharmacy and medical/psychiatry to address this requirement. **Findings:** Same as F.6.a., Recommendation 1. **Recommendation 2, June 2007:** Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified. **Findings:** PSH has yet to implement this recommendation. **Recommendation 3, June 2007:** Develop and implement a monitoring system for this requirement.

Findings:
PSH has monitoring data based on a review of 100% of the recommendations. The data are summarized as follows:

	Sep	Oct	Mean
N	9	9	9
n	9	9	9
%S	100	100	100
Total # of recommendations	9	9	9
a. # Recommendations followed	5	5	1
b. # Recommendations not followed but rationale documented	0	2	1
c. # Recommendations not followed and (rationale) not documented	4	2	3

PSH did not provide information regarding any follow-up done in those situations in which the physician did not respond to the pharmacist's recommendations and/or disagreed with the recommendations without documentation of an acceptable rationale.

Compliance:
Partial.

Current recommendations:
1. Continue to monitor this requirement.
2. Provide follow-up regarding situations in which the physician did not respond to the pharmacist's recommendation and/or disagreed with

		the recommendation without documented acceptable rationale. Assign responsibility and accountability to medical/psychiatry for plans of corrections for problems identified.

7. General Medical Services		
		Methodology: Interviewed: 1. Dominique Tran, MD, Physician and Surgeon 2. Cleveland Wright, MD, Physician and Surgeon 3. Niculina Tanase, MD, Staff Psychiatrist 4. Cung Nguyen, MD, Physician and Surgeon 5. My Tran, MD, Physician and Surgeon 6. Khanh Ngo, MD, Physician and Surgeon 7. George Proctor, MD, Staff Psychiatrist 8. Hum Bui, MD, Physician and Surgeon 9. Aung Zin, MD, Physician and Surgeon 10. Bong Doan, MD, Staff Psychiatrist 11. Paul Kratofil, DO, Staff Psychiatrist 12. Mohamed Hafez, MD, Physician and Surgeon 13. Christopher Elder, MD, Nurse Coordinator 14. Daryl Brown, Administrator of medical services 15. Katherine Smith, RN, Standards Compliance Auditor 16. Mubashir Farooqi, MD, Staff Psychiatrist Reviewed: 1. The charts of 13 individuals who were transferred to an outside medical facility during this review period;: HPR, JCS, FGP, SLT, JT, MAS, TMA, AJV, PRM, GH, JHP, WPW and TS 2. AD #10.47, Medical Services (November 2007) 3. Draft AD #10.25, Medical Emergencies (October 2007) 4. AD #10.01, PSH Clinics, Consultants and Referral Services (June 2007) 5. PSH Guidelines regarding Management of Hypertension, Diabetes mellitus and Asthma/COPD (October 2007) 6. PSH Admission Medical Assessment Auditing Form 7. Admission Medical Assessment Auditing summary data (May to

		October 2007) 8. PSH Ongoing Care Monitoring Form 9. Ongoing Care Monitoring summary data (May to October 2007) 10. PSH Urgent and Emergent Care Monitoring Form 11. Urgent and Emergent Care Monitoring summary data (May to October 2007) 12. PSH Medical Conditions Monitoring Form 13. Medical Conditions Monitoring summary data (May to October) 14. PSH Integration of Medical Problems into WRP Monitoring Form 15. Integration of Medical Problems into WRP Monitoring summary data (May to October 2007) 16. PSH summary data regarding Radiology and EKG testing 17. PSH Quality of Care Monitoring Form (Diabetes Mellitus) 18. Quality of Care Monitoring (Diabetes Mellitus) summary data (May to October 2007) 19. PSH Quality of Care Monitoring Form (Hypertension) 20. Quality of Care Monitoring (Hypertension) summary data (May to October 2007) 21. PSH Quality of Care Monitoring Form (Asthma/COPD) 22. Quality of Care Monitoring Form (Asthma/COPD) summary data (May to October 2007) 23. PSH data regarding Return of Medical Records (May to October 2007) 24. PSH data regarding medical peer review
F.7.a	Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Maintain a level of staffing and a range of consultation and referral services that are adequate to meet the medical care needs of its individuals.

	monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.	**Findings:** PSH has implemented this recommendation. The facility has maintained a Medical Services Department that employs a Chief Physician and Surgeon, 19.5 FTE Physicians and Surgeons, 5 FTE nurse practitioners, and 1.5 FTE medical residents performing specialized functions (occupational and preventive medicine). All physicians are licensed in California. Including the Chief Physician, 15 of the physicians are board-certified in various specialties. Including multiple credits for physicians qualified in more than one specialty, the range of specialties includes Internal Medicine (9) with one also certified in Gastroenterology, Family Medicine (5), General Surgery (1), Preventive Medicine (2), Neurology (2), Physical Medicine (1) and Pediatrics/Infectious Disease (1). Medical Staff bylaws require that new hires be physicians who are board-certified or have completed residency training in their specialty area. Of the Staff Physicians and Surgeons, one serves as the Public Health Officer, one specializes in physical medicine, and the remainder have unit medical responsibilities. All units are assigned a medical-surgical physician but most cover more than one unit. The Staff Physicians and Surgeons also have coverage responsibilities in the Admission Suite and Employee Clinic that are shared with nurse practitioners. Nurse practitioners function under the supervision of the physicians and have a manual of protocols to follow that are regularly reviewed and approved by the Interdisciplinary Practice Committee, which includes three physicians. Duties assigned to nurse practitioners include admission and annual histories and physical assessments, Employee Clinic, gynecology screening clinic, and to a limited extent, assisting physicians with sick call. PSH has maintained a range of on-site specialty clinics that currently include internal medicine consultation, surgery, gynecology, neurology,

		infectious diseases (including separate clinics for HIV and TB latent infections), and gastroenterology. Contract consultants privileged at Patton provide additional gastroenterology and neurology services. Additional clinic services provided in-house by non-physicians include screening gynecological exams by nurse practitioners, optometry (contracted), audiology, speech pathology, EKG, EEG (technicians contracted; tracings read by neurologist), physical therapy (contracted), laboratory (contracted, specimens taken to Community Hospital of San Bernardino), and occupational therapy. The facility has maintained contractual arrangements with a range of external outpatient consultations and treatment at Arrowhead Regional Medical Center (the county hospital) and Loma Linda Medical Center for multiple specialties. In addition, private practitioners in the community accept referrals for hematology/oncology, allergy, and therapeutic tattoo removal. Contracts with external clinics and imaging centers are in place for sleep medicine, radiology including MRIs, and renal dialysis. Inpatient services contracts or working arrangements for referrals to outside medical facilities exist with St. Bernardine Medical Center (closest acute care hospital), Community Hospital of San Bernardino, Arrowhead Regional Medical Center, Loma Linda Medical Center, and Riverside County Regional Medical Center (used for mentally disordered inmates from prisons in Riverside County). Skilled Nursing services are provided by Crestview Convalescent Center. Physician services at St. Bernardine Medical Center, Community Hospital and Crestview are provided by two contracted physicians who divide the attending responsibilities. The after-hours coverage (Medical Officer of the Day or MODs) is addressed in F.7.b.iv below.

		Recommendation 2, June 2007: Develop and implement ADs/ Policies and Procedures and/or Duty Statements to codify facility's standards and expectations regarding all the areas of deficiency that were outlined in the monitor's baseline report. **Findings:** PSH has revised AD #10.47, Medical Services, AD #10.25, Medical Emergencies (draft), and AD #10.01,PSH Clinics, Consultants and Referral Services in an effort to address the ten findings of deficiency in the baseline report. The revisions include specifics in the following areas: 1. Requirements regarding completeness of all sections of initial assessments (AD 10.47, #10 and #60); 2. Timeliness and documentation requirements regarding medical attention to changes in the status of Individuals (AD 10.47, #16, #18, #33-38); 3. Requirements for preventive health screening of Individuals (AD 10.47, #10.1.5, #10.2, #10.3, #10.8, #11.6 and #11.10); 4. Physician-nurse communications and physician response within time frames that reflect the urgency of the condition (AD 10.47, #16, #20-22); 5. Emergency medical response system, including drill practice: (AD 10.47, #50-56; draft AD 10.25, #62); 6. Communication of needed data to consultants (AD 10.47, #28 and AD #10.01); 7. Timely review and filing of consultation and laboratory reports (AD 10.47, #17, #24-26 and Nursing Policy 502); 8. Follow-up on consultation recommendations (AD 10.47, #31); 9. Assessment and documentation of medical risk factors (AD 10.47, #10.1.5, #48); and 10. Parameters for physician participation in the WRP process to

		improve integration of medical and mental health care (AD 10.47, #49). These revisions are steps in the right direction. The facility has yet to fully implement this recommendation. Statewide efforts are underway to ensure completion of this task and standardization of the standards regarding medical attention to individuals and the medical emergency response system. **Recommendation 3, June 2007:** Ensure that monitoring instruments are aligned with the ADs/Policies/Procedures/Duty Statements and that the data address not only timeliness and completeness of medical assessments but also quality of assessments and management interventions. **Findings:** An inter-hospital meeting has been scheduled at MSH in December 2007 to implement this recommendation. Meanwhile, the Department of Medicine at PSH has further revised clinical guidelines for diabetes, asthma/COPD, and hypertension to conform more closely with existing audit tools. **Recommendation 4, June 2007:** Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports. **Findings:** Laboratory results are currently being faxed directly from the contract laboratory at Community Hospital of San Bernardino to the PSH units, rather than being sent to a central PSH laboratory office which used to then fax them to the units. PSH reports that this change has sped up delivery of results. The laboratory contract provides for development of a system for electronic transmission of

laboratory results to computer monitors on units. Ongoing meetings between PSH's IT Department and Community Hospital of San Bernardino are still addressing logistics, and the system has not yet been implemented.

Recommendation 5, June 2007:
Ensure that all policies and procedures have standardized format that provides clear information of the sponsor, the approving authority and dates of development, implementation and renewal.

Findings:
PSH has partially implemented this recommendation.

Recommendation 6, June 2007:
Address the deficiencies outlined in the monitor's finding's above and provide corrective actions.

Findings:
PSH has monitoring data based on the current tools. The data are presented in section F.1.c.

Other findings:
This monitor reviewed the charts of 14 individuals who were transferred to an outside medical facility during this review period. The following table outlines the individuals' initials, date/time of physician evaluation at the time of transfer from PSH and the reason for the transfer:

Individual	Date/time of physician evaluation	Reason of transfer
HPR	10/23/07 17:50	Seizure (recurrent)
JCS	05/03/07 12:10	Abdominal Pain (Pancreatitis)

Individual	Date/time of physician evaluation	Reason of transfer
FGP	06/22/07 06:33	Recurrent Priapism
SLT	07/30/07 14:10	Chronic Osteomyelitis
JT	09/30/07 21:00	Abdominal Pain
MAS	05/11/07 13:40	Pneumonia
TMA	07/05/07 07:10	Pneumonia
AJV	10/01/07 21:30	Seizure (new onset)
PRM	06/22/07 22:00	Seizure (recurrent)
GH	09/17/07 09:30	R/O Cryoglobulinemia
JHP	11/2/07 07:15	Coffee-ground emesis
WPW	06/15/07 08:50	R/O Myocardial Infarction
TS	10/29/07 0225	Mortality

The review showed that, in general, the facility provided adequate and timely care. However, there continues to be a pattern of process deficiencies that must be corrected in order to achieve substantial compliance with this requirement. The following are examples:

1. There is no evidence of any records from the general hospital regarding the evaluation and treatment provided at that facility following hospitalizations for recurrent seizure activity (HPR) and for work-up of new onset seizure (AJV).
2. There is no evidence of an evaluation of the individual who had suffered new onset seizure activity (AJV) upon return to PSH to determine possible metabolic causes and need for any modification in treatment to minimize the risk for the individual.
3. An individual has suffered recurrent seizure activity, without

		evidence of a timely neurological consultation (or request for consultation) to modify current ineffective treatment (HPR). 4. There is no evidence of a physician's evaluation within 24 hours of the return of the individual from general hospitalization for generalized tonic-clonic seizure activity (HPR). 5. The nursing evaluation of an individual suffering from abdominal pain did not address the time frames regarding the individual's condition (JCS and JT). 6. There is evidence of delay in the physician's/MOD's response to notification by nursing regarding evaluation of an abdominal pain in an individual who was subsequently diagnosed with partial bowel obstruction (JT). 7. There is evidence of inadequate monitoring of serum amylase in an individual suffering from persistent and poorly controlled hypertriglyceridemia (in excess of 900) while receiving high-risk antipsychotic medication (JCS). The individual subsequently suffered from acute hemorrhagic pancreatitis. 8. The WRP does not include interdisciplinary interventions to address persistent and serious hypertriglyceridemia in an individual (JCS). 9. Upon the transfer of an individual suffering from recurrent psychotropic medication-induced painful priapism, the transfer physician note (and other records) did not include relevant information about medication history. 10. There is evidence of inappropriate selection of an antidepressant medication (buproprion) for an individual suffering from a known seizure disorder (PRM). 11. There is evidence of a lack of nursing attention to a change in the physical status of an individual that resulted in a transfer to rule out myocardial infarction (WPW). **Compliance:** Partial.

		Current recommendations: 1. Revise and implement policies and procedures regarding Medical Attention to Individuals and Medical Emergency Response to correct all of the process deficiencies listed in the previous reports. The standards in these policies and procedures should be implemented across all facilities. 2. Standardize all monitoring instruments regarding this section for use across facilities. The standardized tools must include indicators and operational instructions. 3. Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports. 4. Monitor medical care using standardized tools, provide data analysis and corrective actions regarding low compliance. To standardize the process of data presentation by all facilities, results of monitoring data should be presented for each corresponding cell as follows: a. F.7.b.ii: Admission medical assessment, medical surgical progress notes, emergent medical care, medical transfers to outside facilities, integration of medical conditions into the WRP, and other processes related to laboratory testing, consultations and clinic referrals. b. F.7.c: Quality of care monitoring regarding specific conditions (e.g. hypertension, diabetes mellitus, asthma/COPD, hepatitis, etc).
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental	**Current findings on previous recommendation:**

	care, and laboratory and consultation services;	**Recommendation 1, June 2007:** Same as in F.7.a. **Findings:** Same as in F.7.a. **Recommendation 2, June 2007:** Same as in D.1.c.i. **Findings:** Same as in D.1.c.i. **Compliance:** Partial. **Current recommendations:** 1. Same as in F.7.a. 2. Same as in D.1.c.i.
F.7.b.ii	require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Same as F.7.1.a. **Findings:** Same as F.7.1.a. **Recommendation 2, June 2007:** Ensure that monitoring data address both timeliness of laboratory, x-ray and EKG results and accurate interpretation by the physician. **Findings:** PSH has implemented this recommendation. The facility refined its

monitoring indicators to reflect revisions in AD #10.47, Medical Services. The tools now address both timeliness of reporting and accuracy of interpretation.

Other findings:
PSH used a variety of tools to assess compliance with general elements of medical care. The following is a summary of the data organized by the name of each tool.

PSH Admission Medical Assessment Auditing Form:
The facility reviewed an average sample of 99% of the number of individuals admitted during the month (May to October 2007). The review was conducted by a Standards Auditor. The tool does not include operational instructions. The following are the monitoring indicators and corresponding mean compliance rates. The results of monitoring are consistent with the data reported by the Department of Psychiatry (D.1.c.i).

1.	*The Admission Medical Assessment includes a review of systems*	97%
2.	*The Admission Medical Assessment includes a medical history*	96%
3.	*The admission Medical Assessment includes a physical and neurological examination*	88%
4.	*The admission Medical Assessment includes a diagnostic impression*	96%
5.	*The admission Medical Assessment includes management of acute medical conditions*	94%

All above items have shown improvement from the baseline Self-Assessment by at least several percentage points

PSH Ongoing Medical Care Monitoring Form:
PSH did not identify the sample size. The following are the indicators and corresponding mean compliance rates:

1.	*Has the admission/most recent annual physical exam been completed in a timely manner?*	95%
2.	*Have all the medical conditions been addressed and integrated into the WRP?*	93%
3.	*Has an appropriate medical work-up been done for each condition?*	100%
4.	*Have appropriate consultations been ordered?*	100%
5.	*Has the physician reviewed and followed up on the test results and the recommendations of the consultants?*	93%
6.	*Are the medical conditions diagnosed and treated appropriately?*	100%
7.	*Has the patient received dental care in a timely and appropriate fashion?*	95%
8.	*If required, has the patient received appropriate vision care?*	93%

PSH Urgent and Emergent Care Monitoring Form:
The facility reviewed average sample of 19% of the cases that were identified (by nursing service and the Emergency Care Committee Physicians) as being medical emergencies/urgencies. The tool does not include operational instructions. The following are the indicators and corresponding mean compliance rates. Items 1 through 8 applied to non-life threatening conditions and items 9-11 to life threatening conditions.

1.	*Was the patient seen within two hours for non-life-threatening conditions?*	97%
2.	*Was an appropriate history documented?*	97%

3.	*Was an appropriate physical examination performed and documented?*	96%
4.	*Was an appropriate differential diagnosis generated?*	95%
5.	*If there was tissue damage, was tetanus status ascertained?*	100%
6.	*If patient suffered a human bite or exposure to blood/body fluids was HIV and hepatitis screening performed?*	100%
7.	*Were appropriate diagnostic steps (lab, X-ray) undertaken?*	100%
8.	*Was medical care adequate and appropriate?*	100%
9.	*.If the incident was life threatening,* did the *ambulance/paramedics/ACLS team arrive within fifteen minutes?*	100%
10.	*Was the medical condition recognized in a timely fashion?*	100%
11.	*If the patient was transferred to a hospital outside, was it timely & appropriate?*	100%

PSH has data from two different tools regarding other general elements of medical care that are focused on the integration of medical conditions into the WRP. These tools do not include operational instructions. The following is a summary of the data, including name of the auditing tool, sample size (%S), monitoring indicators and corresponding compliance rates:

Medical Conditions Monitoring Form		
Months:	May-October 2007	
Sample:	Average 14%	
1.	*Each of the open medical conditions listed on the Medical Conditions List are identified in the WRP*	27%

	under Focus #6	
2.	*The WRP identifies the general medical diagnosis*	7%
3.	*The WRP identifies the treatment to be employed for this condition*	2%
4.	*The WRP identifies the related symptoms to be monitored by nursing staff*	5%
5.	*The WRP identifies by what means staff will monitor these symptoms*	1%
6.	*The WRP identifies by what frequency staff will monitor these symptoms*	1%
7.	*Staff to perform these interventions is identified by title*	8%

The facility reports that feedback has been provided to the medical staff and areas of low compliance have been reviewed at department of medicine meetings.

Integration of Medical problems into WRP Form	
Months:	May-October 2007
Sample:	Unspecified
Medical problem has been incorporated into WRP	95%

PSH also assessed compliance with elements of medical care related to diagnostic testing. Using the refined indicators regarding radiology and EKG (see findings under recommendation #1), the facility reviewed variable samples of appropriate targets. The following is a summary of the data, including name of the auditing tool, months of monitoring and sample size (%S), monitoring indicators and corresponding compliance rates:

		Radiology Monitor-Stat Results Months: October 2007 Sample: 100% *Percentage of Stat results provided to ordering physician before the end of the day exam was ordered* — 100% **Radiology Monitor-Accuracy of Target** Months: October 2007 Sample: 100% 1. *Percentage of exams where right individual was x-rayed* — 100% 2. *Percentage of exams where right body part was x-rayed* — 99% **Radiology Monitor-Reporting of Abnormal Results** Months: May-October 2007 *Percentage of abnormal X-rays when the physician and the unit were notified on the day the exam was read* — 100% **Radiology Monitor-Teleradiology Readings** Months: October 2007 Sample: 100% 1. *Percentage of films sent by teleradiology that were verified by radiologist during on-site visit/ primary* — 100%

	reading	
2.	*Percentage of agreements between primary reading and reading by radiologist via teleradiography/ secondary reading*	99%

EKG Monitor-Primary Reading vs. Computer Reading	
Months:	October 2007
Percentage of 12-lead charts where physician's reading substantially agrees with computer reading	100%

EKG Monitor-Overreading of Defibrillator Tracings	
Months:	October 2007
Sample:	29%
Percentage of overreadings (reading by a second qualified physician as a quality measure) in agreement with initial reading (regular reading by a qualified physician)	100%

Laboratory Monitor-Stat Orders		
Months:	May-October 2007	
1.	*Percentage of Stat results that were received in the in-house lab within four hours of pick up by the contract lab*	100%
2.	*Percentage of Stat results provided to the ordering physician within six hours of the time of the order*	100%

		Laboratory Monitor-Critical Value Months: May-October 2007 Sample: 83% *Percentage of critical laboratory value (panic value) called to the unit within 15 minutes of notification by contract lab* 91% **Compliance:** Partial. **Current recommendations**: 1. Same as F.7.1.a 2. Continue to monitor laboratory services. 3. Develop and implement a system to assess timeliness and appropriateness of consultation services. 4. Standardize monitoring tools regarding admission medical assessments, ongoing medical care, emergency medical response and the integration of medical conditions into the WRP. The tools must include indicators and corresponding operational instructions for use across facilities. 5. Develop and implement standardized tool, including indicators and operational instructions, to assess medical surgical progress notes. 6. Provide data analysis and corrective actions regarding areas of low compliance.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as in F.7.a. **Findings:** Same as in F.7.a

		Compliance: Partial. **Current recommendations**: Ensure that the duty statement is aligned with the standardized tools and medical policies and procedures upon their completion.
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure psychiatric input in all psychiatric emergencies that occur after-hours in all sections of the facility. **Findings:** The after-hours coverage (Medical Officer of the Day or MODs) scheduling is assigned to a physician who assures that there is both psychiatric and medical-surgical physician coverage every weekday from 1630 to 0800 the next morning, and 24 hours on weekends and holidays. For this purpose, some physicians classified as psychiatrists (or Medical Director), and who are not members of the Department of Medicine/Medical Services Department are counted as medical-surgical if they are qualified in primary care specialties. All MODs including psychiatrists are required by the Medical Staff to be current in ACLS training. **Recommendation 2, June 2007:** Finalize AD #10.12 regarding physicians' on-call coverage. **Findings:** PSH has implemented this recommendation. **Compliance:** Substantial.

		Current recommendations: Continue current practice and ensure psychiatric input in all psychiatric emergencies that occur after-hours in all sections of the facility.
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue efforts to improve receipt of records from regional medical centers. **Findings:** PSH used its current tracking system to monitor the return of medical records from Arrowhead Medical Center (ARMC). The data show a mean compliance rate of 35% during the period of May to October 2007. The facility recognizes that the record return rates are unacceptable low despite the facility's efforts to obtain these records in a timely manner. **Compliance:** Partial. **Current recommendations**: Continue efforts to improve receipt of records from regional medical centers.
F.7.c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.	**Current findings on previous recommendations:** **Recommendations 1-2, June 2007:** • Continue current monitoring, identify target population and ensure 20% sample size. • Address and correct above-mentioned areas of low compliance.

Findings:
PSH has monitoring data based on the current Quality of Care Monitoring Tools. These tools do not include operational instructions. The instructions are required to standardize the process of monitoring and specify, as indicated, the standard used regarding quality of the service. The following is a summary of these data, including corrective actions that were reported by the facility.

PSH Quality of Care Monitoring Form (Diabetes Mellitus).
During the period of May to September 2007, the facility did not identify the total target population (number of individuals diagnosed with Diabetes Mellitus) and monitoring was based on a review of a number of charts that varied from 17 to 19 per month. In October 2007, PSH reviewed 9% of the charts of all individuals diagnosed with Diabetes Mellitus in the facility (#220). The following are the indicators and corresponding mean compliance rates (May to October 2007).

1.	*If blood pressure is high, has it been treated?*	100%
2.	*Is blood glucose (FBS, Glucoscan) currently monitored at least weekly?*	98%
3.	*Is Quarterly HgbA1C done?*	93%
4.	*Has the lipid profile been done at least annually?*	99%
5.	*If dyslipidemia present, has it been treated?*	96%
6.	*Has urine microalbuminurea ordered at least annually?*	94%
7.	*If urine microalbumin >30 microgram/MG, has ACE-I or ARB been ordered (if not contraindicated)?*	91%
8.	*If the BMI >=27, has it been addressed?*	87%
9.	*Has dietary consultation been ordered?*	97%
10.	*Has diabetes education been given?*	89%
11.	*Is diabetes diagnosis discussed and included in Wellness & Recovery Planning Conference (WRPC)?*	96%
12.	*Was diabetes reevaluated quarterly by physician and*	81%

	documented?	
13.	*Unless contraindicated, (and if individual is age 40 or older), has aspirin been ordered for the individual?*	84%
14.	*Has ophthalmologist/optometrist completed an eye exam at least annually with the individual?*	94%
15.	*Has foot care been given at least annually?*	81%

The facility's data show improvement in addressing elevated BMI, microalbumin within past year and aspirin use (when indicated) as well as documenting diabetes education. The facility reports that compliance rates are greatly influenced by non-adherence of individuals to staff recommendations, and identifies documentation and management of refusals as corrective actions.

PSH Quality of Care Monitoring Form (Hypertension):
During the period of May to September 2007, the facility did not identify the total target population (number of individuals diagnosed with Hypertension) and monitoring was based on a review of a number of charts that varied from 18 to 22 per month. In October 2007, PSH developed a database to determine the total population of individuals with hypertension and reviewed 5% of these individuals (#374). The following are the indicators and corresponding mean compliance rates (May to October 2007):

1.	*Is blood pressure < 140/90 with treatment?*	93%
2.	*Has a lipid profile been checked at least annually?*	100%
3.	*If dyslipidemia is present, has it been treated?*	83%
4.	*If individual has a BMI >=27, has it been addressed?*	73%
5.	*Has a dietary consultation been ordered within 30 days of diagnosis?*	89%
6.	*If individual is currently a smoker, is smoking cessation discussed by physician/nursing staff?*	75%
7.	*Unless contraindicated, (and if individual is age 40 or*	84%

			older), has aspirin been ordered for the individual?	
		8.	*Is hypertension diagnosis discussed and included in the Wellness and Recovery Planning Conference (WRPC)?*	94%

The data showed improvement in the overall control of hypertension, addressing elevated BMI, aspirin treatment (when indicated) and documenting dietary consultations.

PSH Quality of Care Monitoring Form (Asthma/COPD):
During the period of May to September 2007, the facility did not identify the total target population (number of individuals diagnosed with asthma/COPD) and monitoring was based on a review of a number of charts that varied from 21 to 28 per month. In October 2007, PSH developed a database to determine the total population of individuals with asthma/COPD (#203). The facility then reviewed 11% of these individuals. The following are the indicators and corresponding mean compliance rates (May to October 2007).

1.	*In the past 3 months does the individual have dyspnea or wheezing?*	41%
2.	*If dyspnea or wheezing is present: Was a peak expiratory flow rate check and recorded?*	32%
3.	*Is asthma/COPD included in focus 6?*	85%
4.	*Does individual smoke?*	93%
5.	*Is a smoking cessation intervention discussed and included in individual's WRP?*	67%
6.	*Is a smoking cessation intervention discussed and included in physician's progress note?*	47%
7.	*Was asthma/COPD re-evaluated quarterly by medical provider and documented?*	59%
8.	*Is documentation evident of yearly flu vaccination?*	56%

The data show an increase in the use of peak flow meters on some

		programs (the Department of Medicine at PSH has recently determined that they are appropriate for asthma but not routinely for COPD). The facility reports that the data do not fully account for the individuals' refusals because those were frequently not documented. **Recommendation 3, June 2007:** Implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP. **Findings:** The facility reported that a new form has been implemented to ensure this integration. The facility has monitoring data that were presented in F.7.b.iii above. **Compliance:** Partial. **Current recommendations**: 1. Standardize all monitoring tools regarding Quality of Care for specific conditions (Diabetes Mellitus, Hypertension, Asthma/COPD, Hepatitis and others). All tools must include indicators and operational instructions for use across facilities. 2. Monitor this requirement using standardized tools and provide data analysis and corrective actions regarding areas of low compliance.
F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Same as F.7.a. **Findings:** Same as F.7.a.

		Recommendation 2, June 2007: Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. **Findings:** PSH has a peer review system that was described in the previous report. The facility needs to align the indicators used in this system with the new standardized tools (upon their completion). **Recommendation 3, June 2007:** Continue monitoring physicians' adherence to practice guidelines and expand these guidelines to address areas outlined in the triggers/key indicators for medical care. **Findings:** The Department of Medicine at PSH is in the process of updating and expanding clinical guidelines in seven clinical areas: osteoporosis, seizures, physical exams, dysphagia, fall risk, hypertension, and diabetes. Updates to existing guidelines for osteoporosis and diabetes were approved by the Department on May 2, 2007 and are pending formatting for the Department of Medicine manual. An expanded guideline for hypertension has been drafted and will supplement the existing protocol for hypertensive urgency/emergency. In addition, the department has provided input for new hospital wide policies and forms regarding Dysphagia. Work is underway for the final version of the statewide admission history and physical assessment form. **Recommendation 4, June 2007:** Ensure reliability of data on all the medical triggers/key indicators. **Findings:** PSH has developed a medical conditions access database to ensure

		reliability of medical key indicators. At this time, the Standards Compliance auditors keep this database current, with a plan to move to unit staff when they are appropriate trained. The only exception is refractory seizures, which is captured by the Special Incident report (SIR) process. **Recommendation 5, June 2007:** Identify trends and patterns based on clinical and process outcomes. **Findings:** PSH has identified some positive patterns/trends that were described in F.7.1.c. **Recommendation 6, June 2007:** Expedite efforts to automate data systems to facilitate data collection and analysis. **Findings:** PSH reported that implementation began in October 2007. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the indicators used in the physician peer review system are aligned with the standardized monitoring forms regarding admission medical assessments, medical-surgical progress notes, emergency medical response, medical transfer to outside facilities, integration of medical conditions into the WRP and quality of care monitors regarding specific medical conditions. 2. Continue to update practice guidelines guided by current literature and relevant clinical experience. 3. Ensure that practice guidelines are aligned with the standardized

		monitoring forms regarding quality of care for specific conditions. 4. Provide peer review data analysis regarding practitioner and group trends, with corrective actions, as indicated. 5. Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions, as indicated. 6. Finalize efforts to automate data systems to facilitate data collection and analysis.

8. Infection Control		
	Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Rose Bui, MD 2. Chloe Cummings, PHN II 3. Donna Rowe, PHN II 4. Gari-Lyn Richardson, RN, Director Standards Compliance 5. Mary Lou Remetir, RN, Infection Control Nurse 6. Tatiana Rojas, RN, Standards Auditor Reviewed: 1. AD #10.06, Infection Control Committee 2. AD #10.04, Immunization Program 3. PSH's progress report and data 4. Evaluation of the Effectiveness of the Patton State Hospital Infection Control Program, 2006 report 5. PSH Quality Improvement Meeting Minutes for May-September 2007 6. 2007 Risk Assessment for Infection Control report 7. PSH Infection Control Committee minutes dated 9/12/07 8. Medical records for the following 23 individuals: DM, DA, TB, GD CR, JK, HMD, KMH, TEM, JGR, KS, RR, TT, JS, AB, MJ, RC, AC, KC, EYB, RA, MC, and PT 9. DMH Public Health Services HIV Infection/AIDS and Hepatitis reports 10. PSH Infection Control Report Interpretation of October 2007 data 11. Public Health Committee Minutes of Quarterly meeting dated November 15, 2007 (draft)
F.8.a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Partial.

F.8.a.i	actively collects data regarding infections and communicable diseases;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Pursue statewide approval of Infection Control Auditing forms once reliability has been determined. **Findings:** All Infection Control statewide monitoring tools were approved in September 2007. **Recommendation 2, June 2007:** Revise policies and procedures to reflect key elements in the requirements for Infection Control. **Findings:** AD #10.06, Infection Control Program has been adequately revised addressing this recommendation. **Recommendation 3, June 2007:** Develop and implement a system to accurately track immunization and PPD refusals. **Findings:** PSH has temporarily implemented the use of an Excel spreadsheet to collect data regarding immunization and PPD refusals until an Access database can be developed. PSH anticipates this will be done by February 2008. **Recommendation 4, June 2007:** Develop and implement a process for notification by the unit staff when an individual consents and receives the immunization or PPD after they initially refused.

		Findings: AD #10.04, Immunization Program was developed to adequately address this recommendation. **Recommendation 5, June 2007:** Continue to monitor this requirement. **Findings:** PSH data from the DMH IC Admission PPD audit indicated that compliance with notification by the unit to the Infection Control Department for all admission PPD readings was 47% from July-October 2007, based on audited samples ranging from 37% to 85%. Data for May and June were not provided by PSH due to an auditing error that artificially inflated the data. Ongoing training is needed in this area. PSH's data from the DMH IC Annual PPD audit for May-October 2007 based on audited samples ranging from 20% to 77% indicated that compliance with notification by the unit to the Infection Control Department for all annual PPD readings was 40%. PSH's data from the DMH IC Positive PPD audit of 100% of individuals admitted from May-October 2007 with a positive PPD indicated that compliance with notification by the unit to the Infection Control Department for all positive PPD readings was 100%. Data from the DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test audit from May-October 2007 indicated based on a 100% audit sample that there was 0% compliance regarding notification by the unit to the Infection Control Department of refused admission and annual lab work, admission or annual PPDs. From my discussions with the Director of Standards Compliance, data regarding this item needs to be separated.

		PSH's data from the DMH IC Immunization audit from May-October indicated 98% compliance that notification by the lab was made to the Infection Control Department of newly admitted individuals' immunity status and 96% compliance that the lab notified the unit housing the individuals of their immunity status, based on audited samples ranging from 15% to 88%. Regarding immunization refusals, PSH's data from the DMH IC Immunization Refusal audit indicated 0% compliance that the unit notified the Infection Control Department of refusals for immunizations as well as when the individual consented and received the immunizations after refusals from May-October 2007 (excluding August), based on a 100% sample. The progress report indicated that data was not collected in August due to turnover in auditors and a lack of resources. PSH's data from the DMH IC Sexually Transmitted Disease audit for July, September, and October 2007 indicated 96% compliance that the lab notified the unit housing an individual that he/she had a sexually transmitted disease, based on audit samples ranging from 89% to 93%. PSH's data from the DMH IC Hepatitis C audit from May-October 2007, based on a 100% sample, indicated 100% compliance that the lab notified the department of individuals with a positive Hepatitis C antibody and 9% compliance that the lab notified the unit housing these individuals. From my discussion with the Infection Control staff, the low compliance regarding lab notification to the units is due to the auditors not being able to find the lab work in the charts. It appears that this issue is related to the medical records system rather than to a deficit in the laboratory. PSH's data from the DMH IC MRSA audit for May-October 2007 for

		17 individuals diagnosed with MRSA indicated that the lab notified the department 100% of the time when an individual had a positive culture for MRSA, and notification by the lab to the unit was noted at 59% compliance. Again, since notification by the lab is determined through the presence of lab work, the low compliance was due to the lab work not being found in the medical records. PSH's data from the DMH IC HIV Positive audit for five individuals with a positive HIV antibody indicated 100% compliance that the lab notified the department and that the public health unit notified the housing unit when an individual had a positive HIV antibody. From my review of the records of five individuals with a positive PPD (JR, DJ, IM, PK, JB), I found that all five had the appropriate documentation and x-rays, and none were found to have active disease. From my review of the records of five individuals regarding immunizations (CK, TB, CC, CS, JB), I found that JB did not have an order for the Hepatitis A vaccine although lab work indicated that it was needed. In the case of TB, her second Hepatitis B vaccine was not administered until one month after it was ordered, without explanation. From my review of the records of five individuals given admission PPDs (GD, OC, CC, CS, TB), I found that GD's PPD was not given within 24 hours of being ordered. In addition, there was no open problem or care plan found in the WRP for TB's refusal of her second step PPD. The documentation was appropriate for the other three individuals. From my review of annual PPDs for four individuals (RA, MC, PT, DM), I found one PPD not given within 24 hours of the order (RA). From my review of four individuals with HIV (DA, AC, KC, EYB), I found there was no documentation indicating that DA wanted to be tested.

		In addition, the WRPs for KC and EYB were incomplete and did not list the appropriate risk factors. From a review of the records of eight individuals with Hepatitis C (RCH, KS, RR, TT, JS, AB, MJ, RC), I found that the WRP had an open problem but no objectives or interventions addressing the issue for RCH, TT, RR, and MJ. Also, BA's WRP objectives and interventions were not measurable and his strengths were not addressed. From a review of the records of six individuals with MRSA (CR, JK, HMD, KMH, TEM, JGR), I found that four did not have orders for contact precautions, one did not have an open problem in the WRP, and five had open problems but incomplete or inappropriate plans. From a review of the records of four individuals who had sexually transmitted disease screenings (DM, DA, TB, GD), this monitor found that GD had an order to see the gynecologist but found no indication that she went for the appointment or that she refused. In addition, the lab results for Chlamydia and Gonorrhea were not found in her medical record. The documentation for the other individuals was appropriate. Overall from reviews of records of individuals with infectious/ communicable diseases, this monitor found that the data generated from the Infection Control Department was complete and accurate. However, when reviewing data at the unit level, there were a number of problematic issues regarding lab work being placed in the medical records, orders being written and followed within PSH's timeframes, and significant issues with the WRPTs initiating and completing the appropriate documentation in the WRPs related to infection control issues. From review of PSH's Infection Control data and from reviews on site, the Infection Control Department has reliable and consistent systems for receiving and disseminating information regarding

		infectious and communicable diseases. However, there is a significant breakdown at the unit level regarding the use of this information in impacting the health of individuals at PSH with infectious/ communicable diseases. **Current recommendations:** 1. Implement Access data base as scheduled. 2. Develop and implement plans of correction for areas out of acceptable compliance range. 3. Provide necessary training to unit staff regarding their responsibilities for policies and procedures related to Infection Control activities. 4. Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Present data for this requirement in a format that demonstrates compliance with the EP. **Findings:** PSH presented data for this requirement in graphs that could not be interpreted. Per discussion with the Department and Standards Compliance, it was agreed that the use of reports, data graphs generated by Infection Control for their meetings/reports, and any narrative data that reported actual data trends for the facility was appropriate for demonstrating compliance with this requirement. **Recommendation 2, June 2007:** Continue to monitor this requirement. **Findings:** Same as above.

		Other findings: From review of the Infection Control Committee minutes dated 9/12/07 and the Patton State Hospital Infection Control Report Interpretation of October 2007 data, this monitor found sufficient evidence of identified trends and analyses regarding nosocomial infections, community-acquired infections, personnel infections, and types of organisms. Thus far, PSH has not addressed trends regarding individuals who have refused admitting and annual lab work, diagnostic testing, and immunizations. Data from the units regarding these issues need to become consistent in order to adequately assess refusals trends. **Current recommendations:** Continue to monitor this requirement.
F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendations:** **Recommendation, June 2007:** See F.8.a.ii. **Findings:** See F.8.a.ii under Findings for Recommendation 1, June 2007. **Other findings:** The graphic data included in the PSH progress report could not be interpreted. However, documentation was provided from the Infection Control Committee minutes and the 2007 Risk Assessment for Infection Control report at Patton State Hospital indicating that inquires regarding problematic trends are initiated. For example, the documentation indicating that PSH had identified an Upper Respiratory Illness Cluster on Units 34 and 37 during September 2007.

		Surveillance and review of all cases were conducted. Staff education was provided on these units during this time. After September 15, no new cases were reported and existing cases resolved within one week. In addition, PSH provided data regarding a large cluster of scabies infestation on Unit 35. The Infection Control Department identified that there was a lengthy delay in receiving a biopsy that proved positive for scabies on 5/31/07, which was not received by the facility until 10/25/07. This delay contributed to the spread and on 10/26/07 all individuals on the unit were treated and the 16 who appeared to be affected were retreated on 11/1/07. Also, 30 employees that were likely exposed were also treated. There has been no further infestation among the individuals or employees. **Current recommendations**: Continue monitoring this requirement.
F.8.a.iv	identifies necessary corrective action;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Increase sample size (n) as the auditing process continues. **Findings:** PSH sample size has increased over the past six months. The implementation of the Excel Infection Control database will facilitate a large audited sample size. I **Recommendation 2, June 2007:** Develop and implement a system to track refusals. **Findings:** A system to track refusals has been developed and implemented, generating some data. However, the units need to consistently report

		refusals to ensure reliable data for refusal issues. **Recommendation 3, June 2007:** Revise audit tool for positive PPDs to separate x-ray compliance data and physicians' evaluation compliance data. **Findings:** The DMH IC Positive PPD Auditing form has been adequately revised addressing this recommendation. **Recommendation 4, June 2007:** Continue to monitor this requirement. **Findings:** Data from PSH's DMH IC Admission PPD audit indicated that for May-October 2007, PPDs were ordered by the physician during admissions 99% of the time. In addition, the data indicated that for item #3 measuring the ordering of chest x-rays if indicated, which was added in September and audited for September and October, the compliance rate was 100%. The data from PSH's DMH IC Annual PPD audit indicated that from May-October 2007, based on sample sizes ranging from 25% to 77%, there was 88% compliance that physicians ordered PPDs during the annual review. PSH's data from the DMH IC Positive PPD audit for May-October 2007 from a 100% audited sample found 100% compliance that individuals with positive PPDs received an evaluation by the Med-Surg physician and received PA and Lateral chest x-rays. There were no individuals found to have active disease. The data from the DMH IC Immunization audit for May and June 2007

		indicated an 87% and 93% compliance rate respectively that immunizations were ordered by the physician within 90 days. This item was changed with the implementation of the approved statewide tool which measures if immunizations were ordered by the physician within five days of receiving notification by the lab. The data from July-October 2007 regarding the updated item indicated 67%, 55%, 68%, and 64% compliance respectively. PSH's progress report indicated that delays in locating the lab work caused the delay in obtaining the physician's order within five days. However, there was no indication that there was a plan of correction initiated addressing this issue. PSH's data from the DMH IC Sexually Transmitted Disease audit for July, September, and October, based on audited samples ranging from 89% to 93%, indicated 100% compliance that RPRs were ordered during the admission process, 81% compliance that an HIV antibody test was offered to every individual upon admission, and 88% compliance that a Chlamydia and Gonorrhea test were offered during the admission procedure for all female individuals. The data from PSH's DMH IC Hepatitis C audit for May-October 2007 based on a 100% sample indicated 43% compliance that a Hepatitis C tracking sheet was initiated for individuals testing positive for Hepatitis C Antibody and 45% compliance that the individual's medication plan was evaluated for immunizations for Hepatitis A and B. PSH's DMH IC MRSA audit for May-October (excluding August since there were no new MRSA cases) based on a 100% sample indicated 47% compliance that the individual was placed on contact precautions per MRSA policy, 88% compliance that the appropriate antibiotic was ordered for treatment, and 65% compliance that the public health office contacted the unit RN and provided the MRSA protocol and guidance for the care of the individual.

		PSH's data from the DMH IC HIV Positive audit from July-October 2007 based on a 100% sample indicated 100% compliance that individuals admitted with a diagnosis of HIV-positive status were referred to the appropriate clinic and 100% compliance that the individual was seen by the clinic every three months for ongoing care and treatment, unless another timeframe was ordered by the physician. **Current recommendations**: 1. Include information regarding plans of corrections/interventions regarding problematic compliance rates. 2. Continue to monitor this requirement.
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as in F.8.a.iv, Recommendations 1, 2, and 4. **Findings:** PSH's data from the DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test audit for a 100% audited sample from May-October 2007 indicated 12% compliance that there was a focus opened, 4% compliance that appropriate objectives were written for the refusal, and 2% compliance that appropriate interventions were written. PSH's data from the DMH IC Immunization Audit from July-October 2007, based on audited samples ranging from 15% to 88%, indicated 51%, 67%, 74%, and 80% monthly compliance rates that immunizations were administered by the nurse within 24 hours of the physician order. Data for May and June was based on a different indicator prior to the statewide tool being implemented. Data from PSH's DMH IC Immunization Refusal audit for May-October 2007 based on a 100% sample indicated 0% compliance that a focus was

		opened for the refusal, appropriate objectives were developed for the refusal, and appropriate interventions were written. PSH's data from the DMH IC Sexually Transmitted Disease audit for July and September, based on 91% and 93% sample sizes respectively, indicated 100% compliance that the individuals involved in a sexual incident were offered appropriate testing, a focus 6 was opened for all individuals testing positive for a STD, appropriate objectives were written, and appropriate interventions were written. In May, June, August, and October there were no individuals that had been involved in a sexual incident or had tested positive for an STD. PSH's data from the DMH IC Hepatitis C audit from May-October 2007 based on a 100% sample indicated 70% compliance that a focus 6 was opened for Hepatitis, 17% compliance that appropriate objectives were written to include treatment as required by the Hepatitis C tracking sheet, and 2% compliance that appropriate interventions were written to include treatment as required by the Hepatitis C tracking sheet. PSH's data from the DMH IC MRSA audit from May-October 2007, (excluding August since no new MRSA cases were detected), based on a 100% sample, indicated 71% compliance that a focus 6 was opened for MRSA, 24% compliance that appropriate objectives were written to include preventions of spread of infection, and 6% compliance that appropriate interventions were written to include contact precautions. The data from PSH's DMH IC HIV Positive audit from July-October 2007, based on a 100% sample, indicated 100% compliance that a focus 6 was opened for HIV (unspecified viral illness as listed in WRP), 0% compliance that appropriate objectives were written to address progression of the disease, and 60% compliance that appropriate interventions were written.

		As noted previously, compliance rates regarding the integration of open problems for focus 6 and appropriate objectives and interventions into the WRPs at the unit level are significantly hindering overall compliance for Infection Control. **Current recommendations**: Continue to monitor this requirement.
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Develop and implement a system to ensure that Infection Control data is integrated into the facility's quality assurance review. **Findings:** From my review of the PSH Quality Improvement Meeting Minutes for May-September 2007, I found that Infection Control presented an update of their activities regarding the EP consistently; however, there were few clinical issues discussed at these meetings. For example, in May 2007, it was noted that compliance with PPD skin testing for employees was very low but there was no update in subsequent minutes addressing this issue. In addition, the July minutes noted that the EB building has the highest rate of infection. However, no systemic plans of correction or proactive strategies were identified and there was no mention of this issue in subsequent minutes. In addition, the Evaluation of the Effectiveness of the Patton State Hospital Infection Control Program, 2006 report provided considerable information regarding the activities of the department with comparisons from previous years. However, it was not clear from the report what recommendations were implemented from previous years that affected the quality and outcomes of the department. It appears

		that there has been a consistent gap in bridging the information collected by the department and how this information transfers to the individuals on the units regarding education and life style changes. **Current recommendations**: 1. Ensure that follow-up is documented regarding issues identified in the Quality Improvement meeting. 2. Continue to monitor this requirement.

9. Dental Services		
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Dr. Amy Santimalapong, Chief Dentist 2. Gari-Lyn Richardson, RN, Director of Standards Compliance Reviewed: 1. PSH progress report and data 2. Clinic Appointment Refusal Process 3. Dental Exam/Treatment Tracking Data 4. AD #10.14, Dental Services 5. PSH Dental Services Policy ands Procedure Manual 6. PSH Admission Dental Examination Audit form and instructions 7. PSH Comprehensive Dental Examination Audit form and instructions 8. PSH Preventative Dental Care Audit form and instructions 9. PSH Restorative Dental Care Audit form and instructions 10. PSH Refused Dental Exam/Treatment Audit form and instructions 11. PSH Tooth Extraction Audit form and instructions 12. Reviewed dental clinic and medical record dental notes for the following 13 individuals: RE, TO, GT, FT, ES, BJS, CJG, HB, BK, SDC, RBH, KSR, MGT
F.9.a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue to evaluate the need for additional dentists, dental auxiliary staff, and clerical staff for the dental department. **Findings:** PSH progress reported indicated that the Dental Department had submitted a Budget Change Proposal to headquarters that included a request for additional staff: two dentists, two dental hygienists and

		seven dental assistants. The proposal was initially rejected and revisions are currently being made to the proposal to include office staff in the 2008 Budget Change Proposal. **Recommendation 2, June 2007:** Continue efforts to obtain a dental management software package to reduce time spent on recordkeeping and to ensure accurate data. **Findings:** My interview with Dr. Amy Santimalapong, Chief Dentist indicated that the software that was agreed upon by all the Dental Departments was not purchased due to its cost. However, a temporary database has been developed in Excel. This database will be transitioned to the software package that will be procured by DMH. The process to find a cost-effective software package for statewide use is continuing. **Recommendation 3, June 2007:** Develop and implement a system to ensure that current and accurate information regarding dental care and services provided to individuals is included in the unit medical records. **Findings:** Starting October 1, 2007, PSH is now placing the Dental Treatment Plan form (MH5505) into the medical record for all individuals seen at the PSH Dental Department. As individuals are being seen, this form is being placed into the record to ensure that the same information is included in the medical records regarding dental care and services as in the Dental Clinic charts. The department now has a color printer so that copies of the Dental Treatment Plan can be made for the medical records, which alleviates the need to duplicate documentation. **Compliance:** Partial.

		Current recommendations: 1. Continue to evaluate the need for additional dentists, dental auxiliary staff, and clerical staff for the dental department. 2. Continue efforts to obtain a dental management software package to reduce time spent on recordkeeping and to ensure accurate data. 3. Continue to monitor this requirement.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Partial.
F.9.b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure that comprehensive dental assessments are conducted and documented for each individual. **Findings:** At the time of this review, monitoring instruments for the Dental Departments of all four facilities were in the process of being revised/developed for statewide use. In addition, the Dental Departments are in the process of evaluating and modifying the documentation contained in the Dental Assessments and progress notes. As noted in past reports, the data that the Dental Departments have reported in many areas have not adequately or accurately reflected some of the requirements contained in the EP. Up to this time, this monitor has found it difficult, if not impossible, to identify from the dental documentation what comprehensive dental services an individual needed. This has also been the case regarding preventative and restorative care. Justification for tooth extractions are frequently not clearly documented in the progress notes. Although dentists provided during interview sound justifications based on their interpretations of x-rays and other clinical indicators, the

		documentation of this clinical judgment and analysis was not found in the progress notes. In order to verify compliance, this documentation must be included in the progress notes. Since major revisions are being implemented, there were a number of EP requirements that did not have associated data during this review. However, during the review this monitor observed significant efforts by the facility, the Chief Dentist, and the State to address these issues so that adequate and accurate data will be provided during the next review. **Recommendation 2, June 2007:** Provide the Dental Department with assistance regarding presentation of data required by the EP. **Findings:** Standards Compliance has been actively involved in assisting in instrument revision/development and also in providing auditors to review data for the EP. At the current time, the dentists are auditing data regarding tooth extractions until the required documentation for this area is specifically outlined and agreed upon by each Dental Department. From discussions with the Standards Compliance Director, the Auditor for dental and the Chief Dentist at PSH; review of the draft of the monitoring instruments; and discussion of needed changes regarding dental documentation, it appears that the monitoring system for this area should meet all the requirements as outlined in the EP. **Recommendation 3, June 2007:** Review and revise policies and procedures as needed to address this requirement.

		Findings: At the time of this review, AD #10.14, Dental Services and PSH Dental Services Policy and Procedure Manual was in the process of revision and will not be completed until the policies/protocols addressing the issues described under Recommendation 1, June 2007 are determined. **Recommendation 4, June 2007:** Develop and implement a system to monitor and track comprehensive dental services. **Findings:** The following information from an interview with the Standards Compliance Director and a review of PSH's progress report outlines the system being developed and implemented for monitoring and tracking of comprehensive dental services by an auditor from Standards Compliance: • Develop and implement monitoring instruments--currently in process. • Conduct a 100% audit for all individuals that were admitted and enter data for each individual served into an Excel spreadsheet that lists the date of the exam, if any level one priority conditions exist and if so, were they were treated in a timely manner. • Conduct a 100% audit for each individual that has been in the hospital for 90 days. Data will be entered into the Dental Excel Database to track individuals that require preventative or restorative care. • Conduct a 20% random monthly audit on all individuals that have been referred for restorative and preventative care in 90 days. • Conduct a 20% random monthly audit on all individuals who have refused either a dental appointment or a treatment procedure. • Conduct a 20% random monthly audit on all individuals who have had a tooth extraction.

		Other findings: Data for October 2007 from the PSH Comprehensive Dental Examination Audit (inter-rater reliability has not yet been established) indicated from a 100% sample that no comprehensive dental exams were completed within 90 days of admission to the hospital. Revisions regarding the dental documentation for comprehensive dental exams should increase compliance rates. PSH's data for July-September 2007 from the PSH Admission Dental Examination Audit (inter-rater reliability has not yet been established) indicated that 52% of admission dental exams were completed within 30 days of admission and that 90% of individuals who were referred to the appropriate dental clinic were provided treatment within 48 hours (per PSH policy). The audited sample size for these data ranged from 61% in July to 100% in August and September. No data was provided for October. Since there has not yet been a requirement determined for dental documentation of comprehensive dental assessments, this monitor was not able to conduct an independent audit. **Current recommendations:** 1. Implement system to monitor and track comprehensive dental services. 2. Continue to revise dental policies and procedures, including requirements for dental documentation. 3. Continue to monitor this requirement.
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Ensure that dental information contained in individuals' records is

		accurate and up-to-date. **Findings:** See F.9.a. **Recommendation 2, June 2007:** See recommendations for F.9.b.i. **Findings:** See F.9.b.i. **Recommendation 3, June 2007:** Report compliance with all elements of this requirement. **Findings:** The monitoring instrument reviewed by this monitor does not include all the elements of this requirement such as findings, description of treatment provided, and plans of care. These missing elements were discussed with the Chief Dentist and Director of Standards Compliance. Data from PSH's Admission Dental Examination Audit for July-September 2007 indicated that 56% of the admission dental exams were documented on the appropriate form (MH 5505); 49% included instruction for oral hygiene; 90% of had all level one priority conditions identified during the exam; and 90% of individuals identified with level one priority conditions were immediately referred to the appropriate dental clinic. **Current recommendations**: 1. Revise monitoring instrument to include all elements of this requirement. 2. Implement data collection.

F.9.b.iii	use of preventive and restorative care whenever possible; and	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** See recommendations for F.9.b.i. **Findings:** See F.9.b.i. **Recommendation 2, June 2007:** Develop and implement a system to monitor and track the elements of this requirement. **Findings:** At the time of this review, no data was available regarding this requirement. **Current recommendation**: Implement data collection for this requirement.
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Revise the monitoring tool for this requirement to include consistent and specific criteria. **Findings:** PSH has developed the Tooth Extraction Audit Form. However, the specific criteria that should be found in the dental documentation were not included in the tool. Without these criteria, validation of compliance is impossible. This issue was discussed with the Chief of Dental and the Director of Standards Compliance and it was agreed that specific criteria would be included in the tool.

		Recommendation 2, June 2007: Provide training to dental staff regarding this requirement. **Findings:** Although training was provided to the dentists regarding the new dental instruments and the auditing process, additional training needs to be provided regarding requirements for documentation when these have been determined. **Recommendation 3, June 2007:** Present data according to standardized format. **Findings:** Most of the data provided by PSH regarding tooth extractions could not be interpreted except for one item; 100% compliance that x-rays were completed prior to the tooth extraction for June-October 2007 based on sample sizes ranging from 16% to 27%. Based on a review of the records of 13 individuals who had a tooth extraction, the documentation in all 13 cases was significantly better in providing clinical justification for the procedure than in the past. **Recommendation 4, June 2007:** Continue to monitor this requirement. **Findings:** Same as above. **Current recommendations**: 1. Revise the monitoring tool for this requirement to include consistent and specific criteria. 2. Provide training to the dentists once requirements for dental

		documentation is determined. 3. Implement data collection for this requirement.
F.9.c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Revise monitoring tool to include all the elements of this requirement. **Findings:** PSH's current monitoring tool needs address each element of this requirement as a separate item. **Recommendation 2, June 2007:** Use standardized format for presenting data. **Findings:** PSH's data for this requirement could not be interpreted. **Recommendation 3, June 2007:** Continue to monitor this requirement. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: 1. Revise monitoring tool to include each of the elements of this requirement as a separate item. 2. Implement data collection.

F.9.d	Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Use standardized format for presenting data. **Findings:** No data was provided regarding transportation or staffing issues that preclude individuals from attending dental appointments. The data from the PSH Refused Dental Exam/Treatment audit indicated that for 11 individuals who refused two dental exams or treatments during July and August 2007, the unit notified the Dental Department 0% of the time and the Dental Department notified the unit 18% of the time for refusals of dental procedures. Clearly, this system has not been fully implemented. **Recommendation 2, June 2007:** Continue to monitor this requirement. **Findings:** Same as above. **Compliance:** Partial. **Current recommendations**: 1. Provide data regarding all elements of this requirement. 2. Continue implementation and training regarding the refusal process for dental appointments. 3. Continue to monitor this requirement.
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to	**Current findings on previous recommendations:**

	participate in dental appointments.	**Recommendation 1, June 2007:** Develop and implement a system to monitor and track interventions and outcomes for dental refusals. **Findings:** This recommendation was not addressed in the PSH progress report. **Recommendation 2, June 2007:** Develop and implement a facility-wide system to facilitate communication between the Dental Department and the WRPTs regarding individualized strategies to address refusals of dental appointments and treatments. **Findings:** PSH has developed the Clinical Appointment Refusal Process. However, it has not been fully implemented. **Other findings:** The data provided by PSH could not be interpreted. There were a number of items that needed to be reported separately from the PSH Refused Dental Exam/Treatment Audit form. **Compliance:** Partial. **Current recommendations:** 1. Revise current monitoring tool to reflect each element being monitored and tracked. 2. Implement and train staff regarding the Clinic Appointment Refusal Process. 3. Implement collection of data regarding this requirement.

G. Documentation		
G		**Summary of Progress:** Please refer to Sections D, E, F and H for judgments on the progress PSH has made towards aligning documentation practices with the requirements of the EP.
G	Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.	**Current findings on previous recommendations:** **Recommendations 1-4, June 2007:** • Continue to revise, update, and implement policies and procedures related to documentation to address all the requirements of the EP. • Continue to develop and implement a system to monitor and track the quality of documentation. • Ensure staff competency in the implementation of documentation requirements. • Reorganize the charting system to correct the above-mentioned deficiencies. **Findings:** Specific judgments regarding the quality of documentation, as well as progress towards substantial EP compliance and remaining deficiencies, are contained in the discipline-specific subsections of Sections D and F, as well as in Sections E and H. Please refer to these sections for findings (including compliance) and recommendations pertaining to documentation.

H. Restraints, Seclusion, and PRN and Stat Medication		
H		**Summary of Progress:** 1. PSH continues its commitment to decreasing the use of seclusion and/or restraint. 2. PSH's data reflects a more accurate assessment of its seclusion and restraint practices. 3. PSH has revised policies regarding seclusion and restraint in alignment with the requirements of the EP.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. Sarla Gnanamuthu, MD. Medical Director 2. Valerie Pollard, RN, Nursing Performance Improvement Coordinator 3. Regina Olender, Nurse Administrator 4. Lidia Lau, Supervising Registered Nurse, Acting Assistant Coordinator, Nursing Services 5. Carlos Luna, Executive Director 6. Marzina Scott, LVN, Auditor 7. Paul Guest, PhD, Data Consultant 8. Gari-Lyn Richardson, RN, Director Standards Compliance 9. Harry Oreor, Program Director 10. Steve Maurer, MD, Chief of Medical Staff <u>Reviewed</u>: 1. PSH progress report and data 2. AD 15.14, Seclusion or Restraint 3. NP 816, Emergency Use of Behavioral Seclusion or Restraint 4. NP 538, PRN and Stat Medication 5. NP 331, Use of Side Rails 6. Special Order 119.06, Seclusion and Behavioral Restraint 7. Restraint Monitoring Tool

		8. Seclusion Monitoring Tool 9. Staff Development Training Reports 10. Memo dated November 16, 2007 Automatic Stop Date for PRNs/Changed to 15 Days 11. Side Rail Monitoring Tool 12. Results of Side Rail Use Survey report, October 2007 13. Behavioral Guidelines/PBS plans for the following 21 individuals: HHD, ME, RJ, BA, YB, FB, GB, JB, JAC, AC, SC, JC, CC, SD, JD, DRD, KD, BE, DG, TW, OM 14. Medical records for the following 33 individuals: DAA, OC, KLK, GP, ML, WS, CW, MJ, MG, DRD, TA, MB, MAE, GM, JH, JM, DR, DD, HE, RG, LJ, HD, CG, IM, PR, TC, KF, CH, SM, TW, FC, JD, HS
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure that staff training is provided regarding revised policies and procedures addressing the elements of this requirement. **Findings:** Current revisions to AD 15.14 were completed on October 23, 2007. Training rosters indicated that HSSs were trained on 11/8/07 and will be providing training to all nursing staff through 12/07 to address this recommendation. In addition, PSH data indicated that 35% of staff have been trained on Policy and Procedure for Use of Seclusion, Restraint, Psychiatric PRN Medications. Stat Medications and Prohibition of Prone Containment and Transportation. **Recommendation 2, June 2007:** Continue to monitor this requirement. **Findings:** PSH's progress report indicated that there was no use of prone

		containment, transportation or restraint during May-October 2007. The seclusion and restraint monitoring tools have been revised to include the prohibition of prone containment, transportation and restraint as noted from the draft provided by PSH. From my review of 20 restraint episodes involving nine individuals (DA, OC, KK, GP, ML, WS, CW, MJ, MG),I found no indication that prone containment, transportation or restraint was used. **Compliance:** Partial. **Current recommendations**: 1. Continue to provide training regarding this requirement. 2. Continue to monitor this requirement.
H.2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Partial.
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure the monitoring instrument is aligned with the EP. **Findings:** The Restraint Monitoring tool and the Seclusion Monitoring tool have been adequately revised in alignment with the EP. **Recommendation 2, June 2007:** Ensure that items on monitoring instrument measures only one issue. **Findings:** PSH has revised the monitoring tools for Restraint and Seclusion to

		only measure one issue per item. **Recommendation 3, June 2007:** Ensure that staff presenting data are familiar with what the data represents. **Findings:** Staff presenting the data for this section were familiar with the data. **Recommendation 4, June 2007:** Audit episodes of seclusion in alignment with the EP. **Findings:** From review of the data provided by PSH, episodes of seclusion were audited in alignment with the EP. **Recommendation 5, June 2007:** Analyze and present data separately for restraint and seclusion. **Findings:** Some of PSH's data for May-August 2007 were collected using the old monitoring tool, which did not measure only one issue. Consequently, some of PSH's data could not be accurately interpreted and will be reflected in the appropriate section. **Recommendation 6, June 2007:** Ensure staff training is provided regarding the revisions in policies and procedures addressing this requirement. **Findings:** See H.1, findings for Recommendation 1.

		Other findings: The data from PSH's Restraint Monitoring tool from May-October 2007, based on an audited sample size ranging from 14% to 52%, indicated that 44% of the IDN documentation specifically described a hierarchy of less restrictive measures that were considered or exhausted prior to the use of restraints. Additionally, the data showed 100% and 60% compliance for September and October respectively with the requirement that restraint be used only for imminent danger to self, others or property. (PSH's data for May-August 2007 could not be interpreted.) From my review of the records of nine individuals who had a total of 20 restraint episodes, (DAA, OC, KLK, GP, ML, WS, CW, MJ, MG), I found that two episodes included documentation that less restrictive measures were tried and 13 episodes included documentation of an imminent danger to self or others. The data from PSH's Seclusion Monitoring tool from May-October 2007, based on an audited sample size of 100% (14 seclusion incidents), indicated that 50% of the IDN documentation specifically described a hierarchy of less restrictive measures that were considered or exhausted prior to seclusion. Additionally, the data showed 80% compliance in the June-October 2007 period with the requirement that seclusion be only used for imminent danger to self or others. (May data was not provided since items had not been separated at that time). From my review of the records of five individuals who had a total of 20 seclusion episodes (DRD, TA, MB, OC, MAE), I found that five episodes included documentation that less restrictive measures were tried and 16 episodes included documentation of an imminent danger to self or others.

		Current recommendation: Continue to monitor this requirement.
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Revise the monitoring instrument and instructions to reflect the elements of this requirement. **Findings:** PSH has adequately revised the seclusion/restraint monitoring tool to address this recommendation. **Recommendation 2, June 2007:** Continue to monitor this requirement. **Findings:** PSH's data from the Restraint Monitoring tool for September-October 2007, based on audited sample sizes of 21% and 14% respectively, indicated 31% compliance with the requirement that restraint is not to be used for punishment and 30% compliance with the requirement that restraint is not to be used for the convenience of staff. The data regarding active treatment from PSH could not be interpreted. The data indicated 10% compliance that there was evidence that individuals were engaged in active treatment at the Mall for at least 20 hours per week. However, the progress report stated that individuals were enrolled in groups for coping skills and aggression, which they felt would raise the compliance to 100%. From discussion with the auditor for this section, hours enrolled do not indicate engagement in active treatment as outline on the monitoring tool. PSH needs to clarify this issue and present accurate data.

		From my review of the records of nine individuals who had a total of 20 restraint episodes (DAA, OC, KLK, GP, ML, WS, CW, MJ, MG), I found that none of the nine were engaged in 20 hours of active treatment; seven episodes of restraint were not used for punishment, and 13 episodes were not used for staff convenience. PSH's data from the Seclusion Monitoring tool for July-October 2007, based on a 100% audited sample, indicated 54% compliance that restraint was not used for punishment and 46% compliance that restraint was not used for convenience of staff. Again, the data regarding active treatment from PSH could not be interpreted. From my review of the records of five individuals who had a total of 20 episodes of seclusion (DRD, TA, MB, OC, MAE), I found that none of the five individuals were engaged in 20 hours of active treatment; 12 episodes of seclusion was not used for punishment, and 12 episodes were not used for staff convenience. **Current recommendations**: 1. Clarify data regarding active treatment. 2. Monitor this requirement.
H.2.c	are not used as part of a behavioral intervention; and	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Collect, analyze, and present separately regarding this requirement. **Findings:** PSH provided appropriate data addressing this recommendation. **Recommendation 2, June 2007:** Continue to monitor this requirement.

		Findings: PSH's progress report indicated that all Behavior Guidelines (n=67) and all PBS plans (n=3**)** developed as of November 9, 2007 did not include restraints as part of behavioral interventions (100% compliance). From my review of 21 Behavioral Guidelines/PBS plans (HHD, ME, RJ, BA, YB, FB, GB, JB, JAC, AC, SC, JC, CC, SD, JD, DRD, KD, BE, DG, TW, OM), I found no indication that restraint/seclusion were used as part of the behavioral interventions. **Current recommendation**: Continue to monitor this requirement.
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue to monitor this requirement. **Findings:** PSH's data from the Restraint Monitoring tool for May-October 2007, based on sample sizes ranging from 14% to 51%, indicated 37% compliance with the requirement that restraints were terminated as soon as the individual was no longer an imminent danger to self or others. From my review of the records of nine individuals who had a total of 20 restraint episodes, (DAA, OC, KLK, GP, ML, WS, CW, MJ, MG), I found that the documentation indicated that four episodes of restraints were terminated as soon as the individual was no longer a danger to self or others. The data from PSH's Seclusion Monitoring tool from June- October 2007, based on a 100% sample (13 seclusion episodes), indicated 40%

		compliance with the requirement that seclusion was terminated as soon as the individual was no longer an imminent danger to self or others. From my review of the records of five individuals who had a total of 20 seclusion episodes (DRD, TA, MB, OC, MAE), I found that the documentation indicated that 14 episodes of seclusion were terminated as soon as the individual was no longer a danger to self or others. From my discussion with the Medical Director, additional training is scheduled for November and December 2007 to address releasing individuals from restraint/seclusion as soon as they are calm. In addition, PSH reported that they are incorporating this information into the PMAB training for New Employee Orientation and annual training to increase compliance with this requirement. **Current recommendations**: 1. Continue to provide training regarding appropriate release criteria for restraint/seclusion. 2. Continue to monitor this requirement.
H.3	Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Monitor element regarding competency-based training included in this requirement. **Findings:** PSH's training department collects data on all employees regarding PMAB training, which is required for new hires and renewed yearly. This data indicated that 70% of level of care staff (RNs, LVNs, Psychiatric Technicians, and Psychiatric Technician Aides) have received PMAB training that is competency-based regarding seclusion/restraints procedures.

		Recommendation 2, June 2007: Continue to monitor this requirement. **Findings:** PSH's data from the Restraint Monitoring tool for May-October 2007, based on sample sizes ranging from 14% to 52%, indicated 80% compliance with the requirement that an assessment by a physician or licensed clinical professional (Registered Nurse) occur within one hour of a restraint placement. From my review of the records of nine individuals who had a total of 20 restraint episodes, (DAA, OC, KLK, GP, ML, WS, CW, MJ, MG), I found documentation in 16 episodes indicating that an assessment by a physician or RN occurred within one hour of the restraint placement. The data from PSH's Seclusion Monitoring tool from June- October 2007, based on a 100% sample (13 seclusion episodes), indicated 100% compliance with the requirement that an assessment by a physician or licensed clinical professional (Registered Nurse) occurred within one hour of a seclusion placement. From my review of the records of five individuals who had a total of 20 seclusion episodes (DRD, TA, MB, OC, MAE), I found that all 20 contained documentation that an assessment by a physician or RN occurred within one hour of the seclusion placement. **Compliance:** Partial. **Current recommendations**: 1. Continue competency-based training addressing this requirement. 2. Continue to monitor this requirement.

H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Develop and implement definitions that adequately identify PRN and Stat medications. **Findings:** PSH has adequately revised AD #15.14 addressing this recommendation. **Recommendation 2, June 2007:** Develop and implement a reliable system to track PRN and Stat medication use. **Findings:** PSH's current system of tracking Stat and PRN medications remains unreliable. However, in December 2007 the MedSelect System will be implemented hospital-wide, which should ensure the accuracy of Stat and PRN med use. **Recommendation 3, June 2007:** Continue to monitor this requirement. **Findings:** Currently, to ensure reliable data regarding restraint, seclusion, PRNs and Stats, the data is entered in the CIS system by the Central Nursing Office. The data are reviewed by the Data Monitoring Consultant on an ongoing basis to address inaccuracies in the CIS system. **Compliance:** Partial.

		Current recommendations: 1. Implement MedSelect System to ensure accuracy of PRN and Stat data. 2. Continue to monitor this requirement.
H.5	Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Obtain data to reflect this requirement. **Findings:** AD #15.14 was adequately revised to address this recommendation. **Recommendation 2, June 2007:** Monitor this requirement. **Findings:** Although PSH's data from the Restraint Monitoring tool for this requirement could not be interpreted due to two issues being addressed in the same item, PSH recognized that there was a problem with this requirement being implemented. Thus, the trigger information was communicated to the unit psychiatrist, unit supervisors, and the team members. This issue was also addressed in the October and November 2007 Quality Improvement monthly meetings. A system whereby the unit psychiatrists will be reminded via a memo of this requirement has been implemented to increase compliance. No individuals at PSH were in seclusion for more than three episodes in a four week period in the last six months.

		Compliance: Partial. **Current recommendations**: 1. Separate data regarding this requirement. 2. Continue to monitor this requirement.
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	**Compliance:** Partial.
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Develop and implement a monitoring and tracking system addressing the elements of this requirement. **Findings:** PSH has developed the Psychiatry DUE PRN Monitoring Tool and the DMH Stat Psychiatric Auditing Form that adequately addresses this recommendation. Audits for PRN and Stat medications are conducted by Standards Compliance auditors. **Current recommendation**: Continue to monitor this requirement.
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	The data from PSH's Psychiatry DUE PRN Monitoring tool for a 3% audited sample size for August 2007 indicated that 32% of PRNs included rationale for chosen PRN medication and 28% included strategy to modify regular treatment based upon review of its use.

		Current recommendation: Continue to monitor this requirement.
H.6.c	PRN medications are appropriately time limited.	PSH's Pharmacy and Therapeutic Policy regarding automatic stop order for PRN was changed from 45 days to 15 days and monitoring for this requirement will begin in November 2007. **Current recommendation:** Continue to monitor this requirement
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Ensure reliable data regarding PRN and Stat medications. **Findings:** See H.4 under Recommendation 2. **Recommendation 2, June 2007:** Provide training regarding appropriate assessment and documentation of responses to PRN and Stat medications. **Findings:** PSH's progress report indicated that training addressing this recommendation will be provided in November and December 2007. **Recommendation 3, June 2007:** Monitor this requirement. **Findings:** PSH's data from the DMH Nursing Administration of PRN Monitoring Form from May-October 2007, based on sample sizes ranging from 1%to 4%, indicated 57% compliance with the requirement that nursing

		staff assess the individual within one hour of administration of the psychiatric PRN medication and 45% compliance with the requirement that nursing staff document the individuals' response to the PRN medication. PSH's data from the DMH Nursing Administration of Stat Monitoring Form from May-October 2007, based on sample sizes ranging from 8%to 52%, indicated 48% compliance with the requirement that nursing staff assess the individual within one hour of administration of the psychiatric PRN medication and 37% compliance with the requirement that nursing staff document the individual's response to the PRN medication. From my review of the records of nine individuals (GM, JH, JM, DR, DD, HE, RG, ML, WS) who received a total of 79 PRNs, I found that 56 had specific circumstances warranting the PRN documented in the IDNs and that 18 had documentation that included interventions tried prior to the administration of the PRN medication. In addition, I found that 43 had documentation indicating that a nurse assessed the individual within one hour of administration and that 22 had adequate documentation of the individual's response to the PRN administered. From my review of eight individuals who received a total of 24 Stat medications(WS, DRD, MB, TA, ML, MAE, LJ, HD), I found that 20 had specific circumstances warranting the Stat medication documented in the IDNs and that five had documentation that included interventions tried prior to the administration of the Stat medication. Also, 12 had documentation indicating that a nurse assessed the individual within one hour of administration and that eight had adequate documentation of the individual's response to the Stat administered. Overall, I found significant deficits in the documentation of PRN and Stat medications. In many cases, the name of the medication, dose,

		and route were not included in the documentation. In addition, there were a number of PRNs and/or Stats that were not documented at the time that they were given. Also, when injections were administered, the site was frequently not documented. **Other findings:** From my review of five individuals who were placed in restraints, the following issues were identified: In the case of KLK, the nursing documentation indicated that she had become agitated and would not follow staff's direction. After a period of time, she was given an injection of Zyprexa and then placed in five-point restraints. Had she been given the medication as soon as the staff recognized her mood change, the need for restraints may have been adverted. In the case of OC, the nursing documentation indicated that he was given a PRN when he became threatening. However, there was no indication from the documentation if he was agitated earlier than when the PRN was given. While in five-point restraints, he received another PRN medication, but the documentation did not clearly indicate if the second PRN helped decrease his symptoms. In the case of DAA, the documentation indicated that he was placed in five-point restraints after hitting a peer in the shoulder. There was no indication that he was offered a PRN or any alternative measures prior to restraints. The nursing documentation for ML indicated that he was threatening and paranoid at 9 am. He was placed in five-point restraints at 9:55 am. There was no indication that he was offered or given PRN/Stat medication at the time he began to escalate.

		From the nursing documentation for ML, it was impossible to determine when he actually was placed in five-point restraints, the reason, and when he was released. **Current recommendations**: 1. Continue to provide training regarding appropriate assessment and documentation of responses to PRN and Stat medications. 2. Continue to monitor this requirement.
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as in D.1.f. **Findings:** Same as in D.1.f, F.1.b and H.6.a. **Compliance:** Partial. **Current recommendations**: Same as in D.1.f, F.1.b and H.6.a.
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Ensure compliance with this requirement. **Findings:** PSH's progress report indicated that 83% of staff have received the PRN/Stat Medication Requirement In-Service. (Also see H.3)

		Recommendation 2, June 2007: Continue to monitor this requirement **Findings:** Same as above. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
H.8	Each State hospital shall:	**Compliance:** Partial.
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Develop and implement a policy/procedure to outline the facility's standards regarding side rail use consistent with the requirements of the EP. **Findings:** AD #15.14, Seclusion or Restraint and NP 331, Use of Side Rails adequately address this recommendation. **Recommendation 2, June 2007:** Develop and implement a monitoring instrument to accurately monitor this requirement. **Findings:** PSH had developed the Side Rail Use Monitoring Form, which adequately addresses this recommendation.

		Recommendation 3, June 2007: Clarify the use of side rails as restraints. **Findings:** See findings under Recommendation 1. **Recommendation 4, June 2007:** Ensure that procedures are developed to address the use of side rails as a restraint. **Findings:** AD #15.14 and NP 331 adequately address this recommendation. **Recommendation 5, June 2007:** Continue to explore alternative options to side rails such as the use of high-low beds. **Findings:** PSH's progress report indicated that the Program Director of Program 1 has requested the purchase of 10 high/low beds. No further information was provided regarding the status of this request. **Current recommendation**: Continue to monitor this requirement.
H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if	**Current findings on previous recommendation:** **Recommendation, June 2007:** Same as in H.8.a. **Findings:** The data from the Side Rail Use Monitoring Form could not be

	appropriate.	accurately interpreted. Data provided by the facility indicated that 11 individuals (CG, IM, PR, TC, KF, CH, SM, TW, FC, JD, HS) had physician orders for side rails. However, only two (FC and HS) were identified as having restricted movement and mobility because of the side rails. This information did not match with PSH's data. From my review of the records of FC and HS, the WRPs addressed the use of side rails and HS's WRP included strategies to reduce the use of side rails. The medical symptoms warranting the use of side rails were addressed for both individuals. As mentioned above, the Program Director has requested high/low beds to be purchased. **Current recommendations**: 1. Present data to accurately reflect the elements of this requirement. 2. Continue to monitor this requirement.

I. Protection from Harm		
I	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. Standards Compliance has developed procedures for notifying units when an individual has reached a trigger, receiving information from units regarding the actions taken in response to triggers and monitoring the timeliness of these responses and the implementation of a sample of these interventions. 2. The hospital has installed the hospital police information system and is training staff on its use. This will provide PSH with some capacity to track and trend incidents. 3. The timeliness in beginning and closing investigations has improved significantly. 4. Training continues for hospital police, administrators and Program Directors on Incident Management. 5. An Incident Review Committee has been formed and is meeting each month. 6. Staff Development has made a commitment to begin work on a video that will feature individuals discussing life at the hospital to be shown to employees during new employee orientation. 7. Annual training in Abuse/Neglect Recognition and Prevention has been initiated. 8. The hospital has imminent plans to improve the cleanliness of the environment that include more frequent cleaning of restrooms, a revised form for monthly unit inspections, unannounced spot checks of the environment, and assessment by WRPTs of individuals who are not caring for themselves. 9. Revised procedures going into effect in December 2007 will increase attention to the needs of individuals with the condition of incontinence.

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. C. Brown, Standards Compliance 2. G. Richardson, Director, Standards Compliance 3. D. Whaley, Standards Compliance 4. J. DePalma, Standards Compliance 5. A. Hild, Program Director, Statewide Incident Review Committee member 6. L. Glenn, Acting Training Officer 7. J. Reyes, Acting Psychiatric Nursing Education Director 8. V. Martinez, Nurse Instructor 9. B. Sherer, Human Resources Director 10. R. DePalmer, Standards Compliance Reviewed: 1. Mortality Review Committee minutes from April 2006 to present 2. 10 SIRs (incident reporting forms) 3. Headquarters Reportable Brief forms for September 2007 4. 22 investigations completed by the OSI (Office of Special Investigations) 5. 12 Investigation Monitoring Forms 6. Training and background check records for 12 staff members 7. AD #15.13 Patient Abuse and AD #15.14 Seclusion or Restraint 8. Investigation Compliance Monitoring Tool data 9. Incident Review Committee (IRC) minutes for July through October 1, 2007 10. Statement of Rights and Responsibilities for 12 individuals. 11. Aggregate data from Therapeutic Milieu Observation Monitoring Attended: Central/East Council meeting and West Council meeting.

I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	**Compliance:** Partial.
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue with plans for annual abuse and neglect training. **Findings:** Annual abuse and neglect training, as part of block training, was initiated in June 2007. **Recommendation 2, June 2007:** Identify during investigations any incidents of failure to report abuse or neglect and take appropriate action. **Findings:** This recommendation has not been consistently implemented. During the investigation of an allegation of verbal abuse made on 9/8/07 by LFR, a staff member acknowledged that she heard the named staff member use the same abusive language earlier in the day and had not reported it because she was afraid the staff member would "verbally abuse her." The investigator made no recommendation for failure to report and the supervising officer did not identify the omission. Consequently, no action was taken. **Recommendation 3, June 2007:** Ensure that all descriptions of abuse and neglect include the statement that the misuse of restraint and seclusion is abuse.

		Findings: The misuse of restraint and seclusion is listed as an example of physical abuse in the new statewide SIR definitions. AD #15.13 was revised in April 19, 2007 before the new SIR definitions were finalized and some definitions in the AD do not conform to the new SIR definitions. For example, the AD cites the "unauthorized" use of restraint and seclusion as abuse and it prohibits the "unauthorized use of chemical restraints." This phrasing addresses only the necessity to secure proper authorization to use restraint and seclusion and does not address the use of these methods in a manner that violates AD #15.14 governing their use. AD #15.14 prohibits the use of chemical restraint, meaning there can be no authorized use of chemical restraint. **Other findings:** AD #15.13 states clearly "abuse and neglect of individuals is not condoned and shall not be tolerated at Patton State Hospital." **Current recommendations**: 1. Review AD #15.13 and revise it to align with the new SIR definitions. Eliminate reference to the "unauthorized" use of chemical restraint. 2. Identify during investigations any incidents of failure to report abuse or neglect and take appropriate action. 3. The Incident Review Committee should review the failure to report verbal abuse documented in the 9/8/07 incident involving LFR.
I.1.a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death,	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue to work on consistency between the SIR and trigger data.

	abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;	**Findings:** This recommendation has been successfully implemented. **Other findings:** Comparison of SIR data and trigger data for a limited sample of items (falls, deaths, suicide attempts, aggression to self with major injury) revealed consistent data between the two data sources or Standards Compliance was able to show how and why there were differences. Differences were attributable to changes in information that became available after the SIR was written and entered into the SIR database. **Current recommendation**: Continue current practice.
I.1.a.iii	mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Support decisions to remove staff alleged to have engaged in misconduct with a written rationale, as required by AD #15.13. **Findings:** This recommendation has not yet been implemented. The investigations reviewed included a statement that an individual was removed, but did not include a rationale that would distinguish these situations from those in which staff were not removed. **Recommendation 2, June 2007:** Clarify the written guidance to supervisors on those circumstances when separation must occur to prevent an interpretation that would require both an injury and a witness be present. **Findings:** This recommendation has not yet been implemented. AD #15.13 states

		that "alleged perpetrator staff shall be removed from individual contact, pending investigation, whenever there are credible preliminary indications of physical abuse (injury and witnesses)." The SIR definition of physical abuse includes actions that "may cause harm or pain." It does not require an injury. It is quite possible to physically abuse an individual and not leave an injury. The AD should protect individuals by requiring the removal of the staff member in cases where there is credible evidence that abuse may have occurred. **Current recommendation**: 1. Review and revise AD #15.13 to provide protection to individuals in all instances when there is a credible allegation of abuse. 2. The Incident Review Committee should ensure that consideration of separation is documented in those cases where appropriate.
I.1.a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Keep a record of staff members who were requested to attend training a second or third time and determine the reason why this occurred, with the objective of identifying those factors that relate to the work environment (scheduling, short staff situations, etc). **Findings:** The Training Coordinators are required to send a list to Program Directors each month identifying those staff members who did not attend training when scheduled. As indicated below, a review of a small number of staff training records evidenced substantial problems in ensuring staff were trained according to the scheduling method in use. **Other findings:** Scheduling for annual Abuse/Neglect training (part of block training) is based on the staff member's birth month. Ideally, the staff member is

		given a training packet to study, passes a competency test on the material, and then is scheduled for the block training in the month of or the month preceding his/her birthday. Matching the training records and birth months of 12 randomly selected staff revealed that eight of these staff should have received annual training between June, when the training program began, and November 2007. Of the eight staff, only three had actually received the training. PSH reported that beginning in November 2007 it will track staff members who have been out of compliance for two or more months. **Current recommendations:** 1. Begin tracking staff who are seriously out of compliance as planned. 2. Review and refine the procedures for ensuring that staff members take annual training in a timely manner.
I.1.a.v	notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Include in the "What Have We Learned" slides the employment-related consequences of failing to report or impeding reporting, as well as the possible legal consequences. **Findings:** This recommendation has not yet been implemented. The training presentation provided at PSH states only the possible legal consequences for failure to report. It contains no "What Have We Learned" slides that summarize the main points in clear, concise language, as was the purpose of these slides. A slide in the training states that all employees are required to cooperate with hospital police or Special Investigators during an investigation.

		Recommendation 2, June 2007: During investigations, ask individuals to whom they made the first report of the allegation. Take appropriate action if there is reason to suspect that an employee failed to report an allegation. **Findings:** See I.1.a.i for an investigation that uncovered failure to report verbal abuse, but was not pursued. **Recommendation 3, June 2007:** Implement plans to have all staff sign the mandatory reporting forms as they complete annual refresher training and ensure that all staff complete the training. **Findings:** Review of the personnel records of 12 staff members revealed that 11 of the 12 had signed the Mandatory Reporter forms. The one staff member out of compliance was hired over 20 years ago and was not yet due to take annual training. All others had signed on the date of hire. **Other findings:** AD #15.13 addresses the responsibility of staff members to report incidents of suspected abuse and neglect citing that the failure to report may result in progressive corrective or disciplinary action. Slide 11 in the presentation "Recognizing Elder and Dependent Adult Abuse/Neglect" used at annual training and new employee orientation contains an error in citing the deliberate infliction of pain as an example of psychological abuse. Such an action would be an example of physical abuse. The slide should read the deliberate infliction of mental pain, which is consistent with the SIR definitions.

		Current recommendations: 1. Continue to use annual training as an opportunity to ensure the staff member has signed the Mandatory Reporter form. 2. Revise AD #15.13 to state that failure to report abuse or neglect will result in progressive corrective or disciplinary action. 3. Revise Slide 11 in the annual abuse training presentation. 4. Include the equivalent of "What Have We Learned" slides in the training presentations. Use clear and concise language that addresses abuse and neglect in an institutional setting.
I.1.a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	**Current findings on previous recommendation:** **Recommendation, June 2007:** At the WRPC closest to the anniversary of the individual's admission date, ask him/her to again review and sign the rights statement. **Findings:** PSH reports that it will begin implementation of this recommendation in November 2007. **Other findings:** Review of three records of individuals on an admission unit indicated that each had signed an Acknowledgement of Rights and Responsibilities. Review of the records of nine individuals on other than admission units revealed that the form was signed at the time of admission—one in 1993, one in 1998, six in 2005 and one in 2003. **Current recommendation**: Continue with plans to discuss rights and responsibilities at annual conferences and ask individuals to sign the form at that time.

I.1.a.vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Collaborate with the Councils to identify the "business time" problems and address them in an equitable fashion. **Findings:** It was reported at the Council meetings I attended that time restrictions on when an individual can request assistance at the nursing station, "office calls", have been eliminated hospital-wide. However, some individuals indicated these restrictions are still in place on their units. **Other findings:** PSH has been conducting Therapeutic Milieu Observation Monitoring. One of the items asks if "staff are observed responding to individuals' requests for assistance" and if "more staff are in the milieu than in the nursing station." Data is available for May though August and indicates that the average scores were 79% and 62% respectively. Items with average scores of 15% or less included: • Staff are observed offering praise or positive feedback to individuals. • Staff are heard acknowledging individuals' strengths and abilities. • Staff makes use of language and terms used in recovery training. • Staff encourages individuals to help each other. All individuals I asked were able to explain how to make a complaint and report rights violations. All six units visited had blank complaint forms readily available.

		Current recommendations: 1. Identify the units where "office calls" remain a problem, initiate an equitable solution and monitor compliance. 2. Continue Therapeutic Milieu Observation Monitoring and distribute the results hospital-wide.
I.1.a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue work on the implementation of the statewide Incident Management System. **Findings:** The Standards Compliance staff understand that the statewide Incident Management System should be in operation by the spring of 2008. The delay is due, at least in part, to the need to avoid duplication between the new Incident Management System and the hospital police information system that each hospital has purchased. **Recommendation 2, June 2007:** Use the SIR database and the WaRMSS data to identify individuals who are repeat aggressors, aggressors causing serious injuries, and repeat victims and ensure that appropriate measures are taken to reduce the violence. **Findings:** This recommendation has been partially implemented. The trigger data identifies individuals who are aggressors causing serious injuries to others. Units are alerted and WRPTs take action. There is presently no identification of individuals who are repeat victims or those who repeatedly hurt others but without inflicting serious injury. The hospital reports that when training is completed on the hospital police information system, staff will be able to generate reports of repeat

		aggressors and repeat victims. PSH expects to begin generating these reports in January 2008. No historical data will be put into this information system. **Current recommendation**: Continue training on the hospital police information system and use it initially to generate reports of individuals who are repeat aggressors and repeat victims. Expand tracking of other variables as more information is put into the system.
I.1.a.ix	mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Modify AD #15.13 or place in another appropriate AD protections for individuals, family members and visitors against retaliation. **Findings:** The hospital reports that this change in AD #15.13 will be made in December 2007. **Recommendation 2, June 2007:** Include discussion of retaliation and how it will be handled in the new employee and annual refresher training. **Findings:** This recommendation is partially implemented in that the training asserts that employees will be protected from retaliation. It does not address the possible consequences for threatening or engaging in retaliation. **Recommendation 3, June 2007:** Include the prohibition of and protections against retaliation in a "What Have We Learned" slide that is part of the Incident

		Management Training Manual. **Findings:** As cited above in I.1.a.v, there are no "What Have We Learned" slides in the copy of the training slides provided. **Recommendation 4, June 2007:** Keep in mind the possibility of fear of retaliation in situations where individuals recant allegations, and question the individual appropriately. **Findings:** There is evidence of an investigator's awareness of the possibility of fear of retaliation in one investigation reviewed. In the investigation of an alleged rape of MP by another individual (reported on 8/30/07), the investigator was cognizant of the possibility of retaliatory threats or actions when he/she questioned the alleged victim about whether she recanted her allegation because of threats by the alleged perpetrator or another individual. **Current recommendation**: Proceed with plans to revise AD #15.13 to include protections for individuals, family members and visitors against retaliation for reporting incidents.
I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	**Compliance:** Partial.
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be	**Current findings on previous recommendations:**

	conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	**Recommendation 1, June 2007:** Revise procedures so that investigations that conclude with a finding of staff misconduct are sent directly to Human Resources (HR), either before or at the same time they are sent to the Program Director. This will support the current practice of dialogue and coordination between the Program Director and HR while reducing the possibility that reports that require an HR response will be overlooked. **Findings:** Three of the four investigations reviewed that concluded with findings indicating the need for HR action were transmitted to HR in a timely manner and action had been taken or was being worked on. One incident was too recent to have had HR action. **Recommendation 2, June 2007:** Revise the Nursing Discharge Summary policy to include the information referred to in the Medical Director's review of the death of RC. **Findings:** This recommendation has not yet been implemented. **Recommendation 3, June 2007:** Review the hospital's procedures for the review of deaths. Ensure the exchange and review of information from the investigation by the Office of Special Investigations, the review by the Medical Director and the review in the Mortality Review Committee. **Findings:** There is insufficient information in the Mortality Review Committee minutes to determine what documents beyond the clinical record and the autopsy when available are reviewed.

		Recommendation 4, June 2007: Create a procedure for capturing all recommendations from these various reviews so that implementation can be tracked. **Findings:** None of the Mortality Review Committee minutes for 2007 identified any recommendations for performance improvement. **Other findings:** Mortality Review Committee minutes provide no information about the quality of the review of any particular death and identify no areas for improvement. The evidence available suggests the review of deaths does not meet current practice standards. Incident Management Training was provided at PSH in May, June and August 2007 for hospital police, administrators, Program Directors and Department Heads. Training attendance sheets indicate that 22 hospital police officers attended. The Executive Director, Clinical Administrator, Hospital Administrator, Nursing Services Coordinator and the Director of Human Resources were among the other 39 participants. **Current recommendations:** 1. The Court Monitor will be providing guidance and practice standards to the hospitals regarding the process of death reviews. Revise current policies and practice to come into compliance with the Court Monitor's recommendations. 2. Continue to provide Incident Management Training for all hospital police officers and any other administrators, Program Directors and department heads who have not yet received Incident Management training.

I.1.b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue implementation of the training plan. **Findings:** See above. **Other findings:** All incidents of wrongdoing are investigated by the hospital police or by the Office of Special Investigations. **Current recommendation**: Continue current practice.
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue current practice. **Findings:** Two investigations reviewed specifically describe the careful handling and securing of evidence. Photos and bloody sheets were properly handled in the investigation of the 8/19/07 assault of TD. Evidence in the 9/29/07 rape allegation was also handled appropriately. **Other findings:** None of the investigations reviewed suggested that evidence was not appropriately handled and secured. This is consistent with the hospital's findings provided on the Investigation Compliance Monitoring Forms. **Current recommendation**:

		Continue current practice.
I.1.b.iv	investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Add a question to the monitoring form asking if all relevant parties were interviewed. **Findings:** This recommendation has not yet been implemented. **Recommendation 2, June 2007:** Transition the completion of the monitoring form from the Office of Special Investigations to an uninvolved/objective party, e.g. Standards Compliance. **Findings:** The hospital determined that only the Office of Special Investigations had the expertise to complete the monitoring form. As described below, the monitoring of investigations and completion of the forms continue to be problematic. **Other findings:** Review of the 12 investigations and the Investigations Compliance Monitoring forms for the same investigations that constituted the sample monitored by the Office of Special Investigations (OSI) for September and October 2007 revealed the following problems or discrepancies in findings: • In two of the 11 relevant monitoring forms, question #9 (*Did the investigation provide recommendations for corrective actions?*) was eliminated in the OSI review with no rationale provided. (The remaining investigation was of a death and the

		investigation was completed by local police, thus the omission of question #9 was appropriate.) • Question #9 received a Yes response on four monitoring forms completed by OSI, but should have received a positive response on only two. There were no recommendations made in the other two investigations. The monitoring forms with these errors were for cases #2007-1427 and # 2007-1548. • In the OSI review of #2007-1497, question #14 (*Did the investigation report set forth the names of all persons interviewed during the investigation?*) was given a positive score. The monitoring form fails to note that not all parties listed were interviewed. • In the OSI review of #2007-1475, question #13 (*Does the investigative report set forth explicitly and separately the names of all alleged victims and perpetrators?*) was scored Yes, but actually the victim's name did not appear on the face sheet and he was referred to in the narrative only by his last name. **Current recommendations**: 1. Determine and implement a plan for an objective review of investigations and accurate completion of the Investigation Compliance Monitoring form. 2. Add a question to the monitoring form asking if all relevant parties were interviewed
I.1.b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Current findings on previous recommendation:** **Recommendation, June 2007:** Keep data on all investigations that are not completed within 30 business days to determine the cause of the problem, paying particular attention to investigations that are not begun in a timely manner and those that are begun immediately but in which subsequent work is delayed.

		Findings: As cited in cell I.1.b.iv.2 below, the timeliness of investigations has improved considerably. All investigation reports reviewed showed that work began without delays as soon as the Office of Special Investigations was made aware of the incident. **Current recommendation**: Continue current practice.
I.1.b.iv.2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	**Current findings on previous recommendation:** **Recommendation, June 2007:** See I.1.b.iv.1. **Findings:** PSH reports that 97% of the investigations it monitored were completed within 30 business days. (These compliance figures are based on a sample size from 16% to 40% of the population.) This compliance rate is consistent with the finding that 91% of the 22 investigations reports reviewed met the 30-business-day criterion. Nearly half of the 22 investigations were completed in 15 days or less. **Current recommendations**: 1. Continue current practice of completing investigations in a timely manner. 2. Expand the size of the sample of investigations monitored to at least 25%, since the total number (N) of investigations each month is small, having averaged 24 investigations per month in the six-month period from May to October 2007.
I.1.b.iv.3	each investigation result in a written report, including a summary of the investigation,	**Current findings on previous recommendations:**

	findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:	**Recommendation 1, June 2007:** Write and promulgate a hospital policy that forbids use of the C-clamp hold. **Findings:** The hospital has not written a policy prohibiting the use of the C-clamp. The hospital reported that the use of the C-clamp will be discussed at a statewide meeting in December 2007. **Recommendation 2, June 2007:** Share the new policy with Central Office with the goal that, if approved, it would become policy for the other hospitals covered by the Enhancement Plan. **Findings:** See above. **Other findings:** Each of the 22 investigations reviewed was summarized in a written report. The reports reference which of the interviews were taped. The investigation of the alleged physical abuse of ST (9/7/2007) determined that two staff members refused to provide morning care to a medically frail individual. The investigator concluded that because two other staff soon provided care, there was no harm or risk of harm to the individual. The decision was made to handle this insubordination at the unit level. There was no consideration in the investigation or in the supervisory review of the investigation that the actions of the two named staff constituted neglect. **Current recommendations**: 1. Reference the SIR incident definitions in making determinations in investigations.

		2. The Incident Review Committee should review the investigation report discussed above (ST 9/7/2007) and determine whether appropriate actions have been taken. 3. Ensure that the discussion of the use of the C-clamp includes alternatives, the frequency with which it has been necessary to use it, and the safety risks associated with its use.
I.1.b.iv. 3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Ensure that compound allegations are fully investigated. Divide them into separate incidents and investigations if necessary. **Findings:** See I.1.b.iv.3(ii) for the description of an investigation of a compound allegation—misconduct in the performance of a search and an abuse allegation. Questions remain about if, who, and how many individuals were present during the search. **Other findings:** In four of the investigation reports reviewed, the synopsis of the allegation/reason for the investigation (on the face sheet of the investigation report) did not describe the alleged misconduct under review. For example, in the investigation report of the alleged physical abuse of YW on 8/18/07, the synopsis does not reference any physical abuse, but describes exclusively how staff appropriately reacted when YW became upset when she could not have a food item not on her diet. Similarly, the synopses of the allegations in the investigation reports of the 9/28/07 allegation of physical abuse of JT, the 10/5/07 abuse allegation of JTO and the 9/23/07 allegation of physical abuse of AF fail to describe the allegation. In the latter investigation, the synopsis only describes AF's actions in hurting a staff member and does not mention the allegation of staff misconduct.

		Two investigation reports failed to use the new SIR definitions agreed upon in July 2007. The allegation made by SB concerning the actions of a peer between July and August was labeled psychological abuse. The definition of psychological abuse specifically states that it is an action by other than another individual. Similarly, an allegation made by VY on 9/25/07 that another individual forced him into sexual contact was labeled sexual abuse. The new SIR definitions state that sexual abuse occurs when there is sexual contact between an employee and an individual or when an employee allows sexual contact between individuals, one of whom is not consenting. There was no investigation or suggestion of staff misconduct in this case, so the classification of the incident as sexual abuse is inaccurate. **Current recommendations:** 1. Address the reason for the investigation by providing a description of the alleged misconduct being investigated in the synopsis on the face sheet of the investigation report. 2. Classify incidents and make determinations based on the SIR definitions finalized in July 2007 when conducting administrative, as distinct from criminal, investigations. 3. Ensure that compound allegations are fully investigated. Divide them into separate incidents and investigations if necessary.
I.1.b.iv. 3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendations:** **Recommendation, June 2007:** Ensure that all relevant persons are interviewed face-to-face and as close to the incident in time as possible. Use telephone interviews as a last resort. **Findings:** In four of the investigation reports reviewed, the investigator did not

		identify and interview all witnesses. This problem was evident in the investigation of the alleged verbal abuse of LL reported on 9/20/07. Neither the individual who made the allegation on LL's behalf nor the named staff member was interviewed after LL said the offending remark was made in jest. Although the incident occurred in the dining room, there was no attempt to find other witnesses to verify that the staff member's tone indicated the remark was not intended to be taken literally. In the investigation of the 9/11/07 allegation of verbal abuse of IL and violation of procedures governing searches, the Program Director and Assistant Program Director were present but each was not interviewed regarding both allegations. The investigation report of the allegation of physical abuse of AF (9/23/07) reads as though more than one staff member responded to the staff member's call for assistance; however, only one staff member was interviewed. In the investigation of physical abuse made by PB (8/4/07), the only person interviewed was the alleged victim, PB. **Current recommendation**: Take steps to identify all witnesses, document these efforts in the investigation report and interview all witnesses identified or explain why an interview was not completed.
I.1.b.iv. 3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue current practice. **Findings:** In two investigation reports reviewed, the names of the alleged victims were not identified on the face sheet, but appeared in the interview summaries. These investigations involved the allegation of verbal abuse of LL reported on 9/20/07 and the 8/19/07 investigation of the assault upon TD by a peer.

		In the latter investigation, the staff member named as performing 1:1 supervision is inconsistent. The Special Investigator report cites a different staff member than is cited on the hospital police report. **Current recommendation**: Identify the alleged perpetrator (with title) and the alleged victim on the face sheet of each investigation report.
I.1.b.iv. 3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, June 2007:** See I.1.b.iv.3(ii). **Findings:** In all 22 investigation reports reviewed, the persons interviewed were identified. However, as cited in I.1.b.iv.3(ii), not all witnesses were interviewed and when an incident occurred in a public area, there was no documentation to indicate that the investigator sought out other witnesses. **Current recommendation**: Identify and interview all witnesses, including individuals, who might have seen or heard an incident.
I.1.b.iv. 3(v)	a summary of each interview;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Interview relevant parties in a timely manner. **Findings:** Delays in conducting investigations were noted in two investigations. These delays are not attributable to the Office of Special

		Investigations. In one investigation reviewed, delay in notifying the Office of Special Investigations resulted in a delay of 2.5 weeks in conducting interviews. The delay was related to the failure to write an incident report about an allegation of neglect concerning MH on 8/31/07. In the allegation of physical abuse of RS (7/19/07), the incident was not reported until 7/31/07 and it reached the Office of Special Investigations on 8/6/07, resulting in a three-week delay in beginning interviews. By the time the investigation was completed on 8/30/07, the staff member was no longer employed at the hospital. In all other investigations reviewed, interviews were conducted in a timely manner. **Recommendation 2, June 2007:** Avoid telephone interviews unless there is no reasonable alternative. **Findings:** No investigations reviewed included telephone interviews. **Current recommendation**: The Incident Review Committee should consider the date of the incident, date reported and date sent to the Office of Special Investigations when it reviews incidents to identify problems and trace them back to the source, so that appropriate actions can be taken.
I.1.b.iv. 3(vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, June 2007:** When the statewide Incident Management System is operational, expand the incident history search on staff members whose conduct is being reviewed in order to identify staff who appear repeatedly in incidents. Take appropriate proactive steps to provide necessary training and supervision.

		Findings: In several of the incident investigations reviewed, a narrow review of the incident history of the named staff member and the alleged victim was documented. Specifically, the investigation report of the alleged physical abuse of YW states that YW made one previous complaint, but does not provide information about the incident history of the named staff member. The investigation report of alleged abuse of PB (8/4/07) states that the named staff member had no sustained abuse allegations and the alleged victim had made no prior abuse allegations against the named staff person. Similarly, in the investigation of the allegation of neglect (8/31/07), the report states that the named staff member had no prior sustained allegations and the alleged victim had made no prior allegations against the named staff member. The statewide Incident Management System and the hospital police information system will eventually provide a fuller picture of the incident history of individuals and staff members. **Other findings:** Documents reviewed in the course of an investigation were identified on the face sheet in the investigations reviewed. **Current recommendation:** Expand the incident history search of both staff and individuals as the technology becomes available.
I.1.b.iv. 3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	**Current findings on previous recommendation:** **Recommendation, June 2007:** See recommendation in I.1.b.iv.3(vi). **Findings:** See above. The incident history review of the individuals and staff

		involved in incidents is narrow and includes only founded allegations. The identification of patterns of allegations regarding specific staff and individuals will be available when the statewide Incident Management System has been operational for a period of time. **Current recommendation**: See I.1.b.iv.3(vi)
I.1.b.iv. 3(viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** See Recommendation 1 in cell I.1.b.i. **Findings:** Presently programmatic recommendations are not commonly identified. This is one responsibility of the Incident Review Committee, which requires more information to meet this obligation. See below. **Recommendation 2, June 2007:** Ask the Incident Review Committee to review this incident. **Findings:** I have no evidence this recommendation was implemented. **Other findings:** The identification of systemic and programmatic recommendations for corrective actions in response to incidents is the responsibility of the Incident Review Committee (IRC). Presently this committee is hampered in that work because it receives only a 2-3 sentence summary of the incident and investigation findings. In the absence of the IRC being able to provide a critical look at the entire incident and investigation, the hospital has no mechanism to identify corrective measures beyond the referral of staff members to Human Resources,

		as appropriate. **Current recommendation**: Provide the full investigation summary to IRC members. Develop procedures to ensure confidentiality of this material.
I.1.b.iv. 3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Current findings on previous recommendation:** **Recommendation, June 2007:** Improve documentation of attempts to reconcile conflicting evidence. **Findings:** In the investigation of staff misconduct during a locker search made by IL on 9/11/07, the question of which individuals were present and how many individuals were present was not resolved. **Current recommendation**: Improve documentation of attempts to reconcile conflicting evidence.
I.1.b.iv. 4	staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, June 2007:** See recommendations in cell I.1.b.iv. **Findings:** The problems in the investigations cited in this report were not identified in the review of the investigation reports by the Supervising Special Investigator. **Other findings:** For the months May-August 2007, the Investigation Compliance Monitoring forms completed by the Office of Special Investigations rated each of the 19 reviewed investigations in 100% compliance with

		each of the 21 items on the form, with the exception of a single investigation in June which did not commence within 24 hours of the incident reporting. This is not consistent with my findings. **Current recommendations**: 1. Develop procedures for a more rigorous and objective review of investigations and completion of the monitoring form. 2. Provide the Incident Review Committee with copies of the complete investigation summaries so that they can fulfill their responsibilities for a thorough review of serious incidents.
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** See cell I.1.b.i. **Findings:** Four of the investigations reviewed required actions by HR as determined by the Office of Special Investigations. One was too recent to expect HR to have taken action, an adverse action was being written in the second and third incidents, and an adverse action was completed in early November in the fourth incident. None of these included action for the failure to report verbal abuse described in I.1.a.i **Recommendation 2, June 2007:** Correct the typing error in AD 2.03AA that calls for "problematic" corrective actions to be identified. It should read "programmatic" corrective actions. **Findings:** The Standards Compliance Director explained her purpose in reviewing corrective actions. In some instances, she is reviewing corrective

		measures that appeared reasonable at the time, but have turned out to be problematic. Thus, the wording "identifying problematic corrective actions" can stand or be changed as the hospital sees fit. **Recommendation 3, June 2007:** Continue plans to initiate an Incident Review Committee and provide the resources necessary for Standards Compliance to begin monitoring corrective actions. **Findings:** An Incident Review Committee began work in July 2007 with the identification of committee members and ground rules for operation. The Committee's responsibilities, as documented in the July minutes, include the review of "all other cases that are identified by the Office of Special Investigation that may require corrective action." Implementation of the recommendation in I.1.b.iv.3 (viii) to provide the IRC with the entire investigation summary will enhance the ability of the Committee to determine corrective actions for any case. **Compliance:** Partial. **Current recommendation**: Supply the IRC with the complete investigation summary for all investigations completed by the Office of Special Investigations so that it can identify needed systemic and programmatic corrective actions.
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	**Compliance:** Partial.

I.1.d.i	type of incident;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue work in the implementation of the statewide Incident Management System. This recommendation will apply to all portions of the Enhancement Plan that deal with tracking and trending of incidents. **Findings:** This broad recommendation for work on the statewide Incident Management System stands. Until this system is operational, PSH and the other hospitals are severely hampered in their ability to meet the requirements of the Enhancement Plan related to tracking and trending of incidents. **Other findings:** The present SIR data system can produce a listing of incidents by type and other variables. It is not capable of producing tracking and trending reports. "Type" is the only variable in the system that is changed when additional information is obtained that changes what has been reported. For example, if the incident was reported as having occurred in the bathroom, but was later determined to have occurred in the bedroom, the location of the incident is not changed in the database. **Current recommendations**: 1. Continue work in the implementation of the statewide Incident Management System. 2. Determine the business rules for ensuring that the information in the statewide Incident Management system is corrected when necessary.
I.1.d.ii	staff involved and staff present;	**Current findings on previous recommendation:**

		Recommendation, June 2007: Continue defining the business rules for the statewide Incident Management System. Ensure appropriate "read rights" to investigators so that they can access a staff member's or an individual's incident history. **Findings:** Work on the statewide Incident Management System is continuing. Presently work is focused on avoiding duplication between this system and the hospital police information system. **Other findings:** The hospital is presently not able to track incidents by the staff member involved. It does not collect the names of staff members present unless the staff member had a role in the incident. **Current recommendation**: Begin using the hospital police information system as quickly as possible.
I.1.d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Report monthly on individuals who are repeat victims and track this information over time when the statewide Incident Management System is operational. **Findings:** The statewide Incident Management System is not yet in operation and will not be for several months. The trigger data does not include information on repeat victims or on individuals who repeatedly aggress against others but do not cause serious injury.

		Current recommendation: Remind WRPTs , Unit Supervisors and Program Directors that they are responsible for identifying repeat victims and taking protective measures, in the absence of a data system that provides this information.
I.1.d.iv	location of incident;	**Current findings on previous recommendation:** **Recommendation, June 2007:** See cell I.1.d.i. **Findings:** The SIR database includes information about the location of incidents, but cannot track or trend this data. Tracking and trending will not be done until there is sufficient information in the hospital police information system or in the statewide Incident Management System. **Current recommendation**: Continue training staff to use the hospital police information system and continue to work on reconciling that system with the statewide Incident Management System.
I.1.d.v	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, June 2007:** See I.1.d.i. **Findings:** The list of incidents produced for this tour was run by date and included the type of incident, unit and program, names of individuals involved, the level of treatment provided, and a short description of the incident. The total number of incidents for each month was also provided.

		The volume of incidents prevents hand tabulation of patterns and trends. **Current recommendation**: Begin putting information into the hospital police information system as soon as possible.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendation:** **Recommendation 1, June 2007:** Complete the Briefing Form for Headquarters Reportable incidents. **Findings:** This recommendation has not yet been implemented. A review of the Headquarters Reportable Briefs completed on incidents occurring in September 2007 (this month was chosen to ensure that adequate time had elapsed for the briefing forms to have been completed) revealed that in none of the three forms were sections III through VII completed. It had been determined that identifying the contributing factors (part of Section IV: Analysis) would meet the intent of this cell. Thus, the need for PSH and the other hospitals to begin completing this form. **Recommendation 2, June 2007:** Consider "contributing factors" when determining variables for tracking and trending. **Findings:** See above. Information on contributing factors is not yet available. **Current recommendation**: Begin completing the Headquarters Reportable briefing forms.

I.1.d.vii	outcome of investigation.	**Current findings on previous recommendation:** **Recommendation, June 2007:** See cell I.1.b.i. **Findings:** The outcome (determination) of the investigation is not part of the SIR database. This information will be available in the hospital police information system. **Current recommendation**: Continue to train staff on the hospital police information system so that the hospital can begin using it as soon as possible and can provide outcome information to the Incident Review Committee and in other appropriate forums.
I.1.e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to	**Current findings on previous recommendation:** **Recommendation, June 2007:** Provide a written rationale for decisions made during an incident investigation to remove a staff member or to allow him/her to continue working with individuals. **Findings:** Several of the investigations reviewed contained information indicating that the named staff member was removed from the alleged victim. Guidance for making these determinations is provided in AD #15.13. No rationale was provided, however, that would differentiate those incidents from others in which separation did not occur.

	such individuals.	**Other findings:** Review of the personnel records of 12 randomly chosen staff members revealed that each had cleared the criminal background check on or prior to the date of hire. These 12 staff members had dates of hire that ranged from 1/16/1985 to 2/28/2007. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

2. Performance Improvement		
I.2	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	**Methodology:** Interviewed: 1. R. DePalmer, Standards Compliance 2. G. Richardson, Director, Standards Compliance Reviewed: 1. Twelve clinical records for evidence of actions taken in response to triggers 2. Trigger response monitoring data 3. Aggregate trigger data matched with SIR data for a selected sample
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue current practice. **Findings:** PSH has identified "high-risk triggers" and "low-risk triggers." High-risk triggers include suicide attempts; homicide; homicide attempt, threat or ideation; alleged abuse/neglect/exploitation; and 2:1 observation for psychiatric or behavioral reasons. When an individual meets a high-risk trigger, Trigger Action Sheets, where the WRPT

		documents its response, are sent to units with the expectation that the team will meet on the next weekday and take some action. **Current recommendation**: Identify ways to use the trigger information (e.g. patterns, trends) to assist WRPTs and Program Directors to identify effective interventions on individual and unit levels.
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue current practice. **Findings:** See above. **Current recommendation**: See recommendation in I.2.a.i.
I.2.a.iii	identification of systemic trends and patterns of high risk situations.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue the practice of monitoring TASs for timely completion and provide feedback to the programs and the administration. **Findings:** The hospital has continued to monitor Trigger Action Sheet replies. See I.2.b.ii **Other findings:** PSH is not yet using the trigger information to identify trends and patterns. It does produce frequency data.

		Current recommendation: Identify ways to use the trigger information (e.g. patterns, historical data on individuals) to assist WRPTs and Program Directors to identify effective interventions on individual and unit levels.
I.2.b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue current practice. **Findings:** The clinical judgment of the WRPT, led by the psychiatrist, determines the response to a trigger. The distinction between responses to high-risk and low-risk triggers is not the choice of intervention, but rather the speed with which the response/intervention is to be implemented. High-risk triggers require a next weekday response. **Current recommendation**: Continue to monitor the timeliness of interventions, a sample of interventions for implementation, and provide historical trigger data to teams for individuals. Share tracking and trending information when this becomes available.
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Continue monitoring implementation of TAS responses.

Findings:
PSH has monitored the timely completion of the Trigger Action Sheets. The hospital reports wide variability in timely response during the period May through October 2007 on an average sample of 21%, with all but one month falling below 50%. Compliance has ranged from a low of 9% in August to a high of 70% in June. The October compliance rate was still less than half (46%). The mean compliance rate for the six months was 27%.

Recommendation 2, June 2007:
Continue to report the results to administration and ensure that appropriate actions are taken if compliance does not dramatically improve over April's rate.

Findings:
These results have been reported to the Executive Director, who has reportedly set clear expectations for a timely response to high-risk triggers.

Other findings:
A review of the clinical records of 12 individuals looking for documentation of 20 actions the WRPTs reported having taken in response to triggers yielded the following positive results.

Individual's initials	Response reported by WRT	Response documented in clinical record
HM	Suicide Assessment	10/31/07
GG	Enhanced Obser.	10/17/07
	Homicide Risk Ass.	10/17/07
	1:1	10/17/07
	Stat medication	10/17/07
WS	Medication change	10/30/07

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<tr><td>HD</td><td>Homicide Risk Ass.</td><td>11/5/07</td></tr>
<tr><td></td><td>Medication change</td><td>11/5-6/07</td></tr>
<tr><td>KK</td><td>Medication change</td><td>8/23/07</td></tr>
<tr><td></td><td>TRC consult initiated</td><td>8/29/07</td></tr>
<tr><td></td><td>PBS team consulted</td><td>10/23/07 consult states PBS plan in place for 1 mo.</td></tr>
<tr><td></td><td>Enhanced Obser.</td><td>8/23/07</td></tr>
<tr><td></td><td>Suicide Risk Ass.</td><td>8/23/07</td></tr>
<tr><td>HR</td><td>1:1</td><td>8/28/07</td></tr>
<tr><td>DM</td><td>Debriefed by psychologist</td><td>8/27/07</td></tr>
<tr><td>CS</td><td>WRP modification – dx change</td><td>No documentation of diagnosis change</td></tr>
<tr><td>NG</td><td>Medication change</td><td>10/17/07</td></tr>
<tr><td></td><td>Debriefed by psychologist</td><td>10/12/07</td></tr>
<tr><td>ME</td><td>Medication change</td><td>11/7/07</td></tr>
<tr><td></td><td>2:1</td><td>11/7/07</td></tr>
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Current recommendations:
1. Continue current practice of Standards Compliance staff checking the implementation of a sample of actions reported by WRPTs.
2. Produce historical trigger data by individual to the WRPTs on a periodic basis to enhance the ability of teams to determine whether their interventions are producing positive results. The frequency of these reports should be determined in collaboration with Program Directors.
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<td>I.2.b.iii</td>
<td>formalized systems for the notification of teams and needed disciplines to support</td>
<td>Current findings on previous recommendation:</td>
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	appropriate interventions and other corrective actions;	**Recommendation, June 2007:** Continue current practice that ensures timely notification to teams of individuals who have activated a trigger. **Findings:** Unit supervisors are notified when an individual meets a trigger and are sent a Trigger Action Sheet for completion. The date and the specific trigger are identified. The Unit Supervisor is asked to communicate the information to the team and record it in the daybook. The psychiatrist is asked to ensure that "appropriate plans and interventions are implemented and documented." There is some evidence that units are not being notified in a timely manner. For example, the incident related to KK occurred on 8/23/07, but the Trigger Action Sheet was not sent until 9/10/07. Similarly, the incident involving DM occurred on 8/24/07, but the Trigger Action Sheet was not sent until 9/6/07. **Current recommendation**: Identify the source of the problem in timely notification to the units of high-risk triggers and take appropriate action.
I.2.b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	**Current findings on previous recommendation:** **Recommendation, June 2007:** See recommendations in cells I.2.b.i. through I.2.b.iv. **Findings:** See previous cells in this section. **Current recommendation**: See previous recommendations for continuing current practice and expanding the uses of the trigger information.

I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue current practice with the objective of improving the responses of the WRPTs in completing the interventions they indicated were taken. **Findings:** See I.2.b.ii for hospital data and monitor's data on interventions completed in response to triggers. **Current recommendation**: See I.2.b.ii
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue moving forward with effective measures to reduce the number and frequency of individuals reaching trigger status. **Findings:** Standards Compliance has made progress in the development of procedures for alerting teams when individuals reach triggers, in tracking responses from the teams and in monitoring the implementation of a sample of the interventions cited by the teams in their responses back to Standards Compliance. **Other findings:** A review of the trigger data for Indicators 1 and 2 (aggressive acts to self and aggressive acts to others) shows variability within a limited range. The data indicates a decrease in the number of falls resulting in a major injury, Indicator 7. Indicator 3 (allegations of

		abuse/neglect/exploitation) shows a sharp increase in August, September and October, but this is due to the elimination of the requirement that the allegation be accompanied by an injury. Similarly, the business rules for reporting individuals with a diagnosis of MRSA and those having a diagnosis of fractures have changed. Changes in the business rules for counting individuals meeting triggers makes comparisons month-to-month within a facility or between facilities ill-advised. **Compliance:** Partial. **Current recommendation**: Finalize the business rules for triggers with the approval of the Court Monitor. If there is a need for additional triggers, add them as necessary, but keep the rules firm for the triggers already operating.

3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	**Methodology:** Interviewed: 1. B. Sherer, HR Director and EP team leader for Environmental Conditions 2. B. Ray, Health and Safety Officer 3. E. St. John, Plant Operations 4. E. Halsell, Chief of Plant Operations 5. R. Olender, Nurse Administrator Reviewed: 1. Medical Conditions Report for Incontinence 2. Incontinence Monitoring Data 3. Nursing Policy and Procedure 403: Care of the Individual with a Condition of Fecal or Urinary Incontinence 4. Clinical records of six individuals with the condition of incontinence 5. Unit environmental inspection reports for August and October 2007 for seven units 6. Revised Supervisor's Fire, Health, Safety and Security Inspection Report 7. AD #15.29: Sexual Behavior of Individuals Served Toured: Six units- 23, 32, 25, EB-11, EB-12, EB-02 Attended: Central/East Council meeting and West Council meeting
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Determine the best way to advise staff of the suicide hazards in the

		hospital environment and how to critically evaluate an environment. **Findings:** Beginning in December 2007, Unit Supervisors will use a new form when conducting monthly environmental reviews. This form moves away from a Yes/No format to a Satisfactory/Needs Improvement/Unacceptable format and requires the date of any work orders and the date of correction of any problematic item. It places increased attention on individuals' bedroom and suicide hazards. Specifically, it includes the inspection of bedrooms for cleanliness, ventilation, the condition of mattresses and pillows and adequate linen and has 24 items related to suicide hazards. **Recommendation 2, June 2007:** Follow current practice standards in carefully assessing individuals who may be suicidal. **Findings:** See other sections of this report for findings regarding the adequacy of suicide assessments. **Recommendation 3, June 2007:** Review earlier inspection results when the monthly reports come in to identify units where there is a suggestion that the inspections may be lax. **Findings:** No problems were identified in environmental areas available to individuals in five of the 14 monthly inspections reviewed. None of the 14 inspections identified problems in bedrooms, meaning all beds were clean, mattresses and pillows were in good repair and beds had adequate linen. In contrast, at least one bed in 9 of the 13 bedrooms I inspected did not have adequate linen. Thirteen of the 14 monthly

inspections reviewed did not identify a problem in the bathrooms. These positive results are not consistent with my observations or with the testimony of individuals at the Council meetings, where several individuals attested to problems in keeping bathrooms clean and in ensuring that individuals maintain a reasonable measure of personal cleanliness. I found a strong urine odor in a bathroom on EB-11 (reportedly this bathroom is due to have a fan installed) and a dirty bathroom without adequate supplies on Unit 25. A bathroom on EB-12 also did not have adequate supplies, and tiles needed replacing in the bathroom stalls on EB-02.

Other findings:
A memo was distributed to all Hospital Managers and Supervisors on November 13, 2007 that initiates changes to address cleanliness issues: housekeeping staff will clean restrooms twice daily, change of shift walk-through will include monitoring of cleanliness, individuals with self-care deficits will be assessed by their WRPTs and random inspections will be conducted. This plan was developed in collaboration with the individuals' Senate and Unit Supervisors.

Individuals' responses to Question #5: "The unit is clean" on the semi-annual survey yielded positive results as follows. [Positive = agree or strongly agree]

Program	# Positive Responses	% Positive Responses
Program 1	35	80
Program 3	18	58
Program 4	21	70
Program 5	17	49
Program 6	47	69
Program 7	29	60
Program 8	32	71

		Compliance: Partial. **Current recommendation**: Implement the plan described above and monitor results, including asking for feedback during Council meetings.
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	**Current findings on previous recommendation:** **Recommendation, June 2007:** Raise expectations with staff and individuals regarding cleanliness and agree on a system for more frequent monitoring of cleanliness in individuals' personal space and in common areas. **Findings:** See I.3.a where a revised monthly inspection procedure is described. See also the recommendation above for unannounced spot-checks and ADL focus in WRPs. These may address the problems that are still evident. **Other findings:** The hospital reports that 52 work orders for problems related to high temperatures were received in the six-month period, May through October 2007. Forty-six of these were addressed on the same or next day. Thirty-nine work orders were received during the same time period related to cold. All were addressed on the same or next day. All units visited had comfortable temperatures during my tour. **Compliance:** Partial. **Current recommendation**: Proceed with plans to enhance cleanliness in individuals' personal space

		and common areas.
I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	**Current findings on previous recommendations:** **Recommendation 1, June 2007:** Make the remaining agreed-upon changes in the incontinence monitoring tool. **Findings:** This recommendation was implemented and the form has been adopted by DMH. **Recommendation 2, June 2007:** Determine when incontinence is serious enough to be included in the WRP. **Findings:** Prior to the availability of the Medical Conditions Report, an individual was determined to have a condition of incontinence if an episode was reported by the unit to CNS and from there to Standards Compliance. The Medical Conditions Report, which only recently became available, identifies individuals who have a diagnosis of incontinence as determined by a chart review. Matching the two sources of information revealed the following: • Nine of the 12 individuals on the Medical Conditions Report listed as having a diagnosis of incontinence established in the period June through October 2007 do not appear on the nursing incontinence sheet as having had an episode of incontinence. • Three individuals who are listed on the nursing incontinence sheet as having had an episode in three of the five months

between June and October do not appear on the Medical Conditions Report. (The nursing report does not indicate the frequency of the condition in any given month for a particular individual.)

These findings suggest that in at least some cases either individuals have the condition of incontinence but the diagnosis has not been established, or nursing is not reporting all incontinence episodes.

Other findings:
PSH has revised Nursing Policy and Procedure #403 addressing the care of individuals with incontinence. This policy places responsibility on the physician to determine when to include incontinence on the Medical Conditions list.

A review of the clinical record of six individuals identified as having the condition of incontinence using sections of the monitoring tool used by PSH yielded the following results:

Individual	Incontinence addressed in present status	Objectives in WRP support dignity	Identified in Focus 6	Interven-tions address Nursing response
RR	Yes	No	NO (d/c'd)	No
BP	Yes	No	Yes	Yes
AW	Yes	No	Yes	No
TN	No	Yes	Yes	Yes
RC	Yes	Yes	Yes*	Yes
JD	Yes	Yes	Yes*	Yes
% compliance	83%	50%	83%	66%

		<table><tr><td>PSH 10/07 % compliance</td><td>25%</td><td>22%</td><td>75%</td><td>0%</td></tr></table> *Incontinence identified in Focus 4 **Compliance:** Partial. **Current recommendations**: 1. Continue to produce both reports and cross-check them until the hospital is satisfied that the Medical Conditions Report is accurate and reliable as the sole source of this information. 2. Implement the new nursing procedures regarding incontinence care.
I.3.d	Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue with current plans to review and revise the relevant Special Orders and Administrative Directives. **Findings:** PSH recently revised (November 16, 2007) AD #15.29 addressing sexual behavior of individuals. In brief, the AD prohibits intimate sexual contact, permits non-intimate touching and cites legal sanctions for non-consensual sexual activity. The AD provides intervention guidelines for staff when they observe unacceptable/dangerous/non-consenting sexual activity. The hospital also revised AD #15.20 addressing sexual assaults. It establishes as priorities immediate medical attention to the victim and maintenance of constant observation and separation of the victim and alleged perpetrator pending the arrival of the hospital police or Special Investigators.

		Other findings: The investigation of non-consensual activity reported by WD (8/19/07) was appropriately handled. Similarly, the rape allegation made by MP (July and August), later recanted, was also handled well. **Compliance:** Partial. **Current recommendation**: Monitor compliance with the new Administrative Directives #15.29 and #15.20.
I.3.e	Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.	**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue efforts to bring all staff training up to current levels. **Findings:** The hospital's data indicates that many of the non-clinical Mall service providers have not completed the required eight courses. Of the 54 non-clinical staff reviewed who were providing Mall services, only six had completed the Mental Health 101 course and for three additional staff this course was not required because the staff were privileged or licensed. This resulted in a compliance rate of 11.8%. Abuse and Neglect training, Patients Rights and PMAB had compliance rates of less than 50%. Compliance was much higher for Recovery (90%) and By Choice (87%). **Other findings:** Staff Development does not have a list of non-clinical staff providing Mall services.

		Compliance: Partial. **Current recommendation**: Share the list of non-clinical staff providing Mall services with Staff Development, so that SD can track training compliance.

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. Individuals reported being pleased with the Neighborhood Watch meetings where they meet with representatives of the hospital police. Individuals did not offer complaints about treatment by police. 2. Baseline data has been gathered with a survey focused on quality of life issues. 3. The two Councils continue to meet and pursue their Top 10 issues list.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology:** Interviewed: 1. C. Clark, Individual/Administration Liaison 2. P. McCord, Supervising Advocate Specialist [These were conversations before and after the Council meetings.] 3. Several individuals during tours Reviewed: August survey results from individuals Observed: Posters and Patient Rights Advocate complaint forms on six units Attended: Central/East Council meeting and West Council meeting
J		**Current findings on previous recommendation:** **Recommendation, June 2007:** Continue with plans for training for hospital police in how to interact

cooperatively with staff and therapeutically with individuals.

Findings:
Neighborhood Watch meetings are held each month, attended by interested individuals, staff and hospital police. The hospital also plans to put two slightly edited copies of the Hospital Policy Manual in the library.

Other findings:
Information for contacting the Patients Rights Advocate and blank forms for making a complaint were available on the six units visited.

When I questioned individuals at the Council meetings about the Neighborhood Watch meetings, those who had attended spoke positively about them and encouraged others to attend.

A 20-item survey form (provided by DMH to be used at all the hospitals) was distributed to individuals in August 2007 and will serve as PSH's baseline. Positive results on five selected items are reported below:

Item	% Positive Responses
Staff recognize my strengths/abilities	69
Staff recognize when I achieve my goals	68
When staff talk, they also listen	73
Staff treat me with dignity and respect	69
Staff address medication concerns	69

During the Council meetings, several individuals, seconded by others in

		attendance, complained that not infrequently dining room staff are disrespectful and sometimes verbally abusive. There is some evidence that when an individual writes a letter of complaint or makes an allegation in writing to the Executive Director, the unit is not completing an SIR. This was the case in two of the investigations reviewed—the 7/19/07 incident involving RS and the 8/4/07 incident involving PB. (The letter might have gone directly to the Office of Special Investigations because an investigation was conducted, but there was no SIR.) **Compliance:** Partial. **Current recommendations:** 1. Take actions to improve the relationship between individuals and dining room staff. Provide training on verbal and psychological abuse. 2. Continue Neighborhood Watch meetings and encourage participation. 3. Identify where the SIR process is breaking down when individuals write to the Executive Director and fix it.